JEFFERSON COUNTY DEPARTMENT OF HEALTH
1400 6th Avenue South | Birmingham, AL 35233 (205) 933-9110 | www.jcdh.org
Serving Jefferson County Since 1917

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION *All Sections must be completed*

Patient Name:_____ Patient's Date of Birth:_____ Age:_____

JCDH Medical Record Number: _____ Patient's Address: _____

RELEASE INFORMATION TO:

Name: _____

Address: _____

_____

_____

Phone:_____ EMAIL: _

ROI USE ONLY

INFORMATION TO BE RELEASED BY:

ATTN: Release of Information (ROI)
Jefferson County Department of Health
P.O. Box 2648
Birmingham, Alabama 35202-2648

RELEASE OF INFORMATION DEPARTMENT CONTACT INFO:
(205) 930-1406, (205) 930-1019
Fax: (205) 930-1305 EMAIL: ROI@jcdh.org

DESCRIPTION OF INFORMATION TO BE RELEASED:
Must specify dates of service

❍ Treatment Notes _____
❍ Test/Lab Results _____
❍ Dental _____
❍ Dental *(current x-rays only)* ❍ All X-rays
❍ Partial Record *(specify date range)* _

❍ Immunizations
❍ Demographic Data
❍ Complete Record
❍ Other _____
(Provide description)

PURPOSE OF INFORMATION TO BE RELEASED:

❍ Continuity of Care
❍ Changing Doctor/Health Care Practitioner
❍ Employment
❍ Family/Guardian request
❍ Insurance

❍ Personal
❍ School
❍ Legal
❍ Other _____
(Provide Purpose)

I understand that the information in my health records may include information relating to notifiable diseases, sexually transmitted diseases, acquired Immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral and mental health issues, and services/treatment for alcohol and drug abuse.

I hereby authorize the use & disclosure of my individual protected health information (PHI) as described above. I understand that this authorization is voluntary and I may not be denied treatment, payment, enrollment or eligibility for services based on whether or not I sign this authorization for release of PHI. I understand that if the agency authorized to receive this information is not a health plan or healthcare provider, this information may no longer be protected by federal privacy regulations and is subject to re-disclosure.

I understand that this authorization will expire one year after signature or on / / /. I understand that I may revoke/cancel this authorization at any time by notifying this agency in writing. If I revoke/cancel this authorization, it will have no effect on any disclosures made before the revocation/cancelation.

- Legal Guardians & Patient Representatives must provide proof of their authority to sign for the patient. Examples of proof include: Birth Certificate, Custody order, Court order, etc.

- Patients age 14 and above are required to sign the authorization form. Examples of proof of signature include driver's license, School Photo ID, Non-driver's ID or any other ID with signature.

PATIENT OR NAME OF PERSON AUTHORIZED TO REQUEST DISCLOSURE **RELATIONSHIP TO PATIENT**

_____ _____

Print/Signature/Date Self/Parent/Legal Guardian/Pt Representative

WITNESS

_____ _____

Print/Signature/Date Title

Provide copy to patient/requestor