Jackson County Department of Public Health

PERMISSION TO USE AND DISCLOSE PATIENT HEALTH INFORMATION

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R. § 164.508(c).

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I authorize _____

to use or disclose to _____the following specific protected

health information (***including/excluding (circle one) HIV status and alcohol and drug abuse***:

_____

from the patient record of: _____

The purpose of the use or disclosure is: _____

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in the Jackson County Department of Public Health's Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this Authorization. I also understand that the Jackson County Department of Public Health cannot deny or refuse to provide treatment, payment, or eligibility for benefits if I refuse to sign this Authorization.

I understand that this information may include electronic transmissions, transactions, and facsimiles. I understand that, once the information is disclosed by the Jackson County Department of Public Health, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon 13 months from date of signing.

I have read and understand the information in this authorization form.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent, Legal Guardian, or other Legally Responsible Person (when required) **Date**

_____ _____

Witness **Date**

Jackson County Department of Public Health
538 Scotts Creek Road, Suite 501
Sylva, NC 28779

Phone: 828-586-8994
Fax: 828-586-3493

(Name and Date of Birth or Pt. Label)

Department Use Only

Follow agency procedure to verify and document the client's identity or the authorized representative's authority to act for the client, if an authorized representative is signing the form.

□ The client signed and received a copy of this form (*applies when the Jackson County Department of Public Health initiates the authorization).*

Notes:

Revocation Section

I do herby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____on _____
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)

be rescinded, effective_____. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) (Date) (Signature of Witness) (Date)

_____ _____ _____
(Signature of Authorized Representative) (Date) (Authorized Representative Relationship Authority)