HURON COUNTY HEALTH DEPARTMENT

Attachment 12

Phone: 989-269-9721 1142 South Van Dyke, Bad Axe, MI 48413 Fax: 989-269-4181
www.hchd.us

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Client Name____________________ Date of Birth____________________

Client Address____________________ I.D. # ____________________

I authorize ☒ Huron County Health Department, 1142 S. Van Dyke, Bad Axe, MI, 48413 - Program Immunizations
or
☐ Other ____________________

to release the information contained in my medical records, including but not limited to: Information about communicable diseases and serious communicable diseases and infections, as defined by statute and infections, as defined by statutes and Michigan Department of Public Health rules. (This includes venereal diseases ("VD"), tuberculosis ("TB"), hepatitis B, Human Immunodeficiency Virus ("HIV"), Acquired Immunodeficiency Syndrome ("AIDS"), and AIDS related complex ("ARC"), or other as described.)

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1) Specific type of information to be released and for what period of time information covers:____________________

Immunization Record

2) Name and address of person/facility receiving information:
☐ Huron County Health Department, 1142 S. Van Dyke, Bad Axe, MI, 48413 - Program ____________________
or
☒ Other Caseville Public School

3) Purpose and need for such release: Kindergarten round up

4) Format in which to be released:
☐ Access ☐ Hardcopy ☐Electronic – CD ☐ Electronic – email to ____________________@_______

I understand that this consent can be revoked in writing at any time by completing the HCHD Authorization Revocation form, except to the extent that the Health Department has taken action in reliance on the authorization. Without expressed written revocation by me, this consent expires on:
☐ this date:________________ or ☐ when the following event has occurred: ____________________

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization. Without a signed authorization, no protected health information will be released unless authorized under the Health Insurance Portability and Accountability Act and noted in the Huron County Health Department Notice of Privacy Practices. If you authorize disclosure of protected health information to an entity not required to comply with Health Insurance Portability and Accountability Act, there is a potential that your protected health information will no longer be protected by the privacy rule. I have read and understand this information. I have received a copy of this form and I am the client or am authorized to act on behalf of the client to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

____________________ ____________________
Client or Parent/Legal Guardian Signature/Date Witness Signature/Date

If signed by other than client, please list relationship to client: ____________________