



Public Health
Prevent. Promote. Protect.

**LAFAYETTE COUNTY HEALTH DEPARTMENT
RELEASE OF INFORMATION FORM**

547 SOUTH BUSINESS HWY. 13
LEXINGTON, MO 64067
PHONE: 660-259-4371
FAX: 660-259-6250

For the Use and Disclosure of Protected Health Information (PHI)

Client Full Name: _____ Date of Birth: _____

Address: _____

Sex: ___ M ___ F DCN, SSN, Etc: _____

USE AND/OR DISCLOSE PHI

By signing this Authorization Release Form, I understand that I am giving my permission to Lafayette County Health Department to **use and/or disclose** my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

REQUEST PHI

By signing this Authorization Release Form, I understand that I am giving my permission to Lafayette County Health Department to **Request** my protected health information (PHI), as described in more detail in the paragraphs below, from the following person(s) or organization(s):

Name of person(s) or organization(s): _____

Street Address: _____

City, State & Zip Code: _____

Phone number: (____) _____ Fax number: (____) _____

I specifically authorize the use and disclosure of the following PHI: *(Please provide a detailed description of the treatment and dates of service)* _____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI: _____

I may revoke this authorization at any time by notifying Lafayette County Health Department, 547 So. Business Hwy. 13, Lexington, Missouri, 64067 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Lafayette County Health Department before Lafayette County Health Department received my written notice of revocation.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearing-houses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

I may inspect and upon request receive a copy of the information to be used and disclosed pursuant to this Authorization Release Form. Signature of Client, Parent, Guardian or Other Responsible Person: _____

Relationship to Patient giving representative Authority to act for patient (if applicable): _____

Today's Date _____ Authorization expires one year after date of authorization to disclose information.