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Macon County Public Health

Authorization to Use or Disclose Health Information

Patients Name:

Date of Birth:

I hereby authorize Macon County Public health to **request/release/exchange** (circle one) Protected Health Information. This information can be used by or disclosed to the following organization:

TO/FROM	**TO/FROM**
Macon County Public Health	**Name:**
1830 Lakeside Drive	**Address:**
Franklin, North Carolina 28734	
Phone:	**Phone:**
FAX: (828) 524-6154	**FAX:**

The type of information to be used or disclosed is as follows (check information you want released/requested include other information where indicated):

☐ All services occurring in the last 3 years	☐ Most Recent History / Treatment Plan
☐ Entire Record	☐ Most recent Discharge Summary
☐ Immunization Records	☐ Prenatal Records
☐ List of Allergies	☐ Current Medication List
☐ Lab Results	☐ Pap
☐ Chlamydia	☐ Financial Information
☐ Demographic Information	Other

I understand that the information in my health record may include information relating to (initial services you want released/requested)

☐ Sexually Transmitted Diseases	☐ Family Planning
☐ Acquired Immunodeficiency Syndrome (AIDS)	☐ Human Immunodeficiency Virus (HIV)
☐ Psychotherapy Notes	

The information for which I am authorizing disclosure will be used for the following purpose:

- ☐ Continuity of Care
- ☐ Other (please describe):

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that I may refuse to sign this Authorization. I also understand that Macon County Public Health cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it. I understand that Macon County Public Health may receive compensation for its use/disclosure of the information released following this authorization. This authorization will expire 12 months from the date on which it was signed unless specified otherwise.

Signature of Patient/Legal Representative (relationship) Date

Signature of Witness required when the above signature is by mark (X) Date

This authorization complies with 45 C.F.R. Statute 164.508 (and HIPAA Rule 45 CFR, part 160 & 164) 12/2018