

COLUMBUS HEALTH DEPARTMENT  
240 Parsons Avenue, Columbus, Ohio 43215

**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ ), \_\_\_\_\_,  
*last name first middle maiden name date of birth*

am allowing \_\_\_\_\_ to release the following  
*agency or person releasing information*

information about my health care to \_\_\_\_\_  
*agency or person receiving information*

**Information to be released – Check all that apply:**

- Mental health history       Medical history       Discharge notes       Service notes  
 HIV/AIDS history       Billing       Diagnosis       Lab results  
 Alcohol/drug abuse history       Lab results **with** HIV       Other \_\_\_\_\_

**Information is to be released for the purpose(s) of - Check all that apply:**

- Continuity of care       Making a referral       Informing referral source  
 Reimbursement/benefits       Legal       Other \_\_\_\_\_

The above items may include information about mental health, alcohol/drug abuse, and/or HIV/AIDS.

**Amount of information to be released includes – Check one:**

- last treatment event       all service dates       information from \_\_\_\_\_ through \_\_\_\_\_  
*date date*

**Columbus Health Department MAY NOT deny treatment based on whether you sign this authorization.**

**This information is not re-released unless a court order forces the release.**

**I understand that I may cancel this authorization at any time by sending a written request to the Columbus Health Department. This request will not apply to information already released.**

**This authorization will remain in effect for 60 days after the date I sign it unless another date or event is specified here:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if other than self: \_\_\_\_\_ Witness: \_\_\_\_\_

I HEREBY CANCEL THE ABOVE AUTHORIZATION AS OF THIS DATE:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Redisclosure of alcohol and drug abuse information: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)**

03/23/2009