Jackson County Health Department
313 South Liberty Street
Independence, Missouri 64050

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Patient Name:_____ Date:_____

Date of Birth: _____

I, _____, hereby authorize Jackson County Health Department to release/disclose the records of the above patient to:

_____
(Requestor)

_____
(Street Address)

_____ _____ (_____)_____
(City) (State) (Zip Code) Telephone Number

The following medical records and information (specify dates of service and information requesting):

_____

_____

Purpose:_____

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the contact office below, except to the extent that action has been taken in reliance thereon. This consent, unless expressly revoked in writing earlier, shall expire within one year from the date signed if I have not provided an expiration date or if the following occurs:____ _____. This information will be released only to the person or agency named above. **Contact Office: Jackson County Health Department 313 S. Liberty Street, Independence, Missouri 64050 Fax: 816-404-6418**

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of any medical information requested to the agency or person specified above. **I understand that I do not have to sign this authorization and that my treatment or payment of services will not be denied if I do not sign this authorization.** Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization I am allowing the release of any drug and/or alcohol information to the agency or person specified above. Additionally, I understand that information released may include Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus).

_____ _____
Signature of Patient Date/Time of Consent

_____ _____ _____
Signature of Legally Responsible Party Date/Time of Consent Specify Relationship to Patient

_____ _____
Signature of Witness Date/Time

PROHIBITION ON DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. You have the right to view and receive copies of certain portions of your medical & financial records kept by Truman Medical Centers or our business associates. You may not view or receive copies of any psychotherapy notes, any information that will be used in a civil, criminal or administrative action or proceeding, information restricted under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. **Records disclosed pursuant to this request may be further disclosed and not protected under Federal Law.**