Authorization For Release of Information

Client Name:
Address:
City, State:
Telephone:
This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability
Act of 1996 [45 CFR §164.508].

It authorizes Scotland County Health Department to use/disclose my _____ records to _____ for the purpose(s) of _____.
This authorization is valid until _____.

The person/people authorized to make this use/disclosure is/are _____.

Under the Privacy Rules, I have the right revoke this authorization at any time, and Scotland County Health Department must cease using this authorization. However, Scotland County Health Department
may complete any actions it initiated prior to my revocation and which rely on my _____ records for completion. I understand that by disclosing my _____ records, Scotland County Health Department cannot guarantee the recipient will not use the disclosure in a violation of the Privacy Rules.

I must revoke this authorization in writing and send the revocation to Scotland County Health Department, 214 W. Madison, Memphis Missouri 63555

Please type or print name:_____
Signature: _____
Date: _____