Clark County Combined Health District

Attachment E: Consent to Release Information

Client Name:	(Last)	(First)	(M. I.)	(Maiden/Other)
Date of Birth:	(Month/Day/Year) __ __/__ __/__ __ __ __	**Phone:**		
Address:	(Number/Street)	(City)	(State)	(Zip)

I Hereby Authorize:

_____ Clark County Combined Health District or _____ Agency/Organization listed below:

Name:				
Address:	(Number/Street)	(City)	(State)	(Zip)
Phone:	(Primary) (__ __ __) __ __ __ - __ __ __ __	**Fax:**	(__ __ __) __ __ __ - __ __ __ __	

To Release My Health Information to:

_____ Clark County Combined Health District or _____ Agency/Organization listed below:

Name:				
Address:	(Number/Street)	(City)	(State)	(Zip)
Phone:	(Primary) (__ __ __) __ __ __ - __ __ __ __	**Fax:**	(__ __ __) __ __ __ - __ __ __ __	

I Authorize the Release of the Following Information:

____Entire Medical Record, or

____Other, specified:_____

I understand the following:

1. This authorization will expire one year from date of signature unless otherwise noted. _____
2. I may revoke this authorization at any time by notifying CCCHD in writing. I understand that it will be effective on the date notified. I understand that an exception to the revocation would be the extent that Personnel of CCCHD have already acted upon the authorization to release information.
3. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payments for my healthcare will not be affected if I do not sign this authorization.
5. I have been offered a copy of this signed authorization form.
6. This authorization is not for marketing.

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Client/Personal Representative Signature_____Date: _____

Witness Signature_____Date:_____