Greene County Sheriff's Department

HIPAA Compliant Authorization to Release Protected Health Information

RE:_____ **DOB:**_____ **SSN:**_____

I authorize_____ to release the following information to _____

Information:	Date(s)
_____	_____
_____	_____

I the undersigned to hereby understand that by signing this authorization, I am allowing the release of information to The above named individual or agency. I authorize that any persons, program, school, physician, clinic, hospital, or agency who receives this authorization furnish to the above named individual or agency. full and accurate social, educational, psychiatric, and/or medical documentation of any subject regarding myself and/or any other information requested by the above named individual or agency. and to discuss verbally with the above named individual or agency. This includes the release of any drug and/or alcohol information records* and the release of information regarding HIV/AIDS testing to the above named individual or agency.

Read Carefully: I understand that my medical/mental health records are confidential. I understand that by signing this authorization, I am allowing the release of any medical and/or mental health information to the above named individual or agency. Drug and Alcohol abuse information and records are specifically protected by federal regulations and by signing this authorization without restrictions, I am allowing the release of any drug and/or alcohol records* to the above named individual or agency.

I do herby release any program, person, school, physician, clinic, hospital, or agency from any liability for information furnished pursuant to this authorization.

Copies of this authorization and signatures are to be considered as valid as the original. This authorization is subject to revocation at any time except to the extent that the program, person, school, physician, clinic, hospital, or agency which is to make the disclosure of information has already taken action in reliance on this authorization. This authorization is valid for one (1) year from the date below with my signature, unless this authorization has been previously revoked in writing. I understand that I have a right to a copy of this authorization. I have reviewed and understand the content of this authorization of release of information. My signature confirms that this authorization accurately reflects my wishes.

Signed:_____ Legal Relationship:_____

Dated:_____ Address:_____

* THE FOLLOWING APPLIES TO DRUG AND/OR ALCOHOL TREATMENT INFORMATION RECORDS:
Prohibition on Redisclosure: This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR 2) prohibit further disclosure of drug and/or alcohol abuse treatment information without the specific written consent of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

SUBSCRIBED AND SWORN to before me this _____ day of _____, _____

_____
Notary Public