ALLEN COUNTY
PUBLIC HEALTH
Allen County Combined Health District

Authorization for Release and Examination of Medical Records (PHI)

Patient Name: _____ **Date of Birth:** _____

I hereby authorize and request that you release the records and information to the entity identified below and to furnish a complete copy of the medical record, medical information, also known as PHI and related data for the above identified person. I am aware that there may be information in this medical record that is related to substance abuse, mental illness, and/or HIV/AIDS that is of a highly confidential level.

From:

_____
_____
_____
Phone_____
Fax_____

To:

_____
_____
_____
Phone_____
Fax_____

Purpose of release of information: _____
_____
_____
_____

Type of records to be released: _____

Date(s) of service to be released: _____

I am aware that I can revoke this release at any time prior to the records being released to the above named entity and that this release is valid for a limited time of 90 days.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Signature of ACPH Staff Member **Date**

Office Use Only: **Photo ID Copied:** _____ **(Staff member's initials)**

Records Released by: _____
Signature of ACPH Staff

Public Health
Prevent. Promote. Protect.

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