

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Chattanooga-Hamilton County Health Department
921 East Third Street, Chattanooga, TN 37403

PATIENT'S NAME _____ **BIRTHDATE** ____/____/____

ADDRESS _____
Street _____ **City** _____ **State** _____ **Zip Code** _____

SEND INFORMATION TO: (please be specific)

Name/Organization _____

Address _____

INFORMATION TO BE RELEASED FROM: (please be specific)

Name/Organization _____

Address _____

PURPOSE OF RELEASE:

Continuation of Care Specialist Personal Use Other _____

INFORMATION TO BE RELEASED:

- Medical Record from last two years
- Complete Medical Record
- Immunization Record only
- Other _____
- Release records for the following dates: From _____ To _____

Expiration date for expressed authorization is _____. If a specific date or event is not specified, this authorization will expire six months from the date signed by the patient or legal representative. I understand that I may revoke this authorization in writing at any time, providing the information has not already been released. I understand my treatment at this facility is not based on signing this authorization. I understand that once the information is released per my instructions, the information is subject to redisclosure and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature _____ **Date** _____

Relationship to patient (if other than patient) _____ **Witness** _____

RELEASE REQUIRING SPECIFIC AUTHORIZATION:

My signature below authorizes the release of any information relating to the testing, diagnosis, and treatment for:

- HIV/AIDS Sexually Transmitted Diseases Mental Health
- Substance Abuse Family Planning/Contraceptive Care

Signature _____ **Date** _____

Relationship to patient (if other than patient) _____ **Witness** _____