Washington County Health Department

1302 Pennsylvania Avenue, Hagerstown, MD 21742

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INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize MDH to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms.

☐ **Check if this authorization is for psychotherapy notes.**

If this authorization is for psychotherapy notes, MDH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

SECTION A: Individual's Health Information authorized for Use and Disclosure.

Last Name: First Name: MI:

Street Address: Apt #:

City: State: Zip:

Phone: (home) (work)

Date of Birth: / /

SECTION B: The Use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose.

The purpose of the disclosure (optional):

Who is authorized to Disclose your health information:

PROGRAM NAME(S):

Washington County Health Department
1302 Pennsylvania Avenue
Hagerstown, MD 21742
240-313-3228

Who is authorized to Receive and Use your health information:
NAME(S):
ADDRESS:
TELEPHONE NUMBER:

If the information which the program has includes records or information from another entity, I Do ☐ or Do Not ☐ wish to have that information released under this authorization.

SECTION C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, MDH CANNOT ACCEPT THIS FORM.)
Expiration: This authorization will expire (complete one):

☐ On / /
☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and-or disclosure being authorized)

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to MDH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact the Washington County Health Department. I understand the revocation of this authorization will not affect any action that MHD or others named or unnamed took in reliance on this authorization before MDH received my written notice of revocation.

SECTION D: Signature. To the Individual – Please read the following.

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is voluntary.

I understand that is the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature: Date:

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name:

Relationship to Individuals: