AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, DOB, _____, hereby authorize_____to release my health information, as specified below, to_____

I authorize the following information to be released: _____

[specific description, including identification of portions of records to be released, i.e. narrative summary, assessment, psychiatric or psychological evaluation, progress notes, and/or time periods of treatment records to be released, etc.]

I understand that the information to be released includes: (initial where appropriate)

_____ **Diagnoses and/or treatment relating to other communicable diseases** _____ **HIV test results;**

_____ **Diagnoses and/or treatment for alcohol and/or drug abuse;** _____ **AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;**

Except with the following limitations: _____

_____

This authorization for use/disclosure is for the following purpose:

_____

_____

I understand that if I have authorized disclosure of protected health information to persons who are not required by Federal or State law to keep the information confidential, these persons who are receiving the records may disclose the protected health information to others without our consent or authorization.

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that _____ **[provider/entity releasing the info]** has already taken action in reliance on my authorization.

My written statement that I want to revoke/withdraw my authorization should be delivered to: **Williams County Board of DD**
11246 St. Rt. 15
Montpelier, OH 43543

Media Release (initial to give consent)

_____ I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or videos of the individual named above by the Williams County Board of DD. I also grant to the Williams County Board of DD the right to edit, use, and reuse said products for nonprofit purposes including use in print, on the internet, and all other forms of media. I also hereby release the Williams County Board of DD and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

This Authorization for Release of Information will remain in effect until: _____

_____ Individual/Parent/Guardian/Personal Representative if individual cannot sign
Print Name

_____ _____
(Signature) Date

Minor's signature (needed only if drug/alcohol treatment information is being disclosed)

_____ _____ _____
Print Name (Signature) Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

For Office Use Only:

Staff person releasing information: _____

(Signature)

_____

Print Name

Date information released: _____