DeKalb County Health Department
Prevent • Protect • Promote

Lisa Gonzalez, MPH
Public Health Administrator

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I. I hereby request and authorize: DeKalb County Health Department
2550 N. Annie Glidden Road • DeKalb, Illinois • 60115
Phone: (815) 758-6673

II. To obtain from or release to: _____
Name of Person or Agency

_____
Street Address City State Zip Code

III. From the medical record of _____
Print/Type Name of Client and their Birth Date

IV. The following information:

____ All medical information and reports

____ Prenatal medical record

____ Physical examination report(s)

____ Laboratory report(s)

____ Immunizations

____ X-ray report(s)

____ Medical data for WIC certification

____ Other (specify) _____

Except for the following which expressly may not be disclosed (if none, write "none"):

_____

V. For the purpose of: _____

VI. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. All information I hereby authorize to be obtained from or released to this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by law. I understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. I understand that I may revoke this authorization at any time by providing written notice to the Health Department of my desire to do so. Absent this revocation of Authorization for Release of Medical Information, release will remain in effect for one year following the date of signature unless I specify an earlier expiration date here (specify date):_____.

VII. I have received a Notice of Privacy Practices dated April 14, 2003.

_____ _____
Date Signature of Client/Legal Representative

_____ _____
Witness Legal Representative Relationship to Client

VIII. USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ _____
Date Signature of Client