COLUMBUS HEALTH DEPARTMENT, 240 Parsons Avenue, Columbus, Ohio 43215
Program Name:_______________________________________

AUTHORIZATION TO RELEASE INFORMATION FOR MINORS OR DEPENDENT ADULTS

In an emergency, this form may be used for release of information from another entity. For such use, check program information appropriately.

I ______________________ am allowing ____ to release
parent/guardian *agency, program or person releasing information*

healthcare information about ____________________________________ , whose date of birth is _______,
first and last name of minor or dependent adult *month/day/year*

to ____

____.
agency, program or person receiving information

Information to be released – Check all that apply:

☐ Mental health history ☐ Medical history ☐ Discharge notes ☐ Services notes
☐ HIV/AIDS history ☐ Billing ☐ Diagnosis ☐ Lab results
☐ Alcohol/drug abuse history ☐ Other____

Information is to be released for the purpose(s) of - Check all that apply:

☐ Continuity of care ☐ Making a referral ☐ Informing referral source
☐ Reimbursement/benefits ☐ Legal ☐ Other________________________________

The above items may include information about mental health, alcohol/drug abuse, and/or HIV/AIDS.

Amount of information to be released includes – Check one:

☐ last treatment event ☐ all service dates ☐ information from ________ through ________
date *date*

Columbus Health Department MAY NOT deny treatment based on whether you sign this authorization.

The information is not re-released unless a court order forces the release.

I understand that I may cancel this authorization at any time by sending a written request to the Columbus Health Department. This request will not apply to information already released.

This authorization will remain in effect for 60 days after the date I sign it unless another date or event is specified here: ____

Signature:____ Date:____________________
parent/guardian

Relationship to minor child or dependent adult:_________________________Witness:______________________________

I HEREBY CANCEL THE ABOVE AUTHORIZATION AS OF THIS DATE:

Signature: Date:

Redisclosure of alcohol and drug abuse information: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987)