Hancock Public Health

Your Recognized Leader in Population Health

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Authorization to Release/Obtain records

Patient Name: _____ **Date of Birth:** _____

This authorization is effective from _____ through _____
(not to exceed 1 year)

_____ I am requesting to obtain vaccination records and/or TB records for myself or my child. (Must have photo I.D.)

____ I am the patient and authorize _____ (Must have photo I.D.) to obtain vaccination records and/or TB records on my behalf.

____I am the parent/legal guardian of the above patient and authorize _____ (Must have photo I.D.) to obtain vaccination records and/or TB records for the patient.

I hereby request/authorize Hancock Public Health (HPH) to obtain/disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke the authorization in writing addressed to the Privacy Officer at the address above. This authorization may not be revoked where HPH has reasonable acted in reliance hereupon.

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

PRINT Patient/Parent/Legal Guardian name: _____
SIGN Patient/Parent/Legal Guardian name: _____
Relationship _____ Date: _____

Party receiving request (HPH Employee): _____