

LIVINGSTON COUNTY HEALTH DEPARTMENT
P. O. Box 650, 310 E. Torrance Ave.
Pontiac, IL 61764
Phone: 815-844-7174, Fax: 815-844-7468

**AUTHORIZATION FORM FOR RELEASE
OF PROTECTED HEALTH INFORMATION ON SELECTED TESTS**

I, _____ hereby authorize LIVINGSTON COUNTY HEALTH DEPT.
(Name of Patient or Personal Representative)

to release the information listed below to:

- | | |
|--|---|
| <input type="checkbox"/> School/Preschool (1) | <input type="checkbox"/> Nursing Home (5) |
| <input type="checkbox"/> Head Start (2) | <input type="checkbox"/> Employer (7) |
| <input type="checkbox"/> Public Aid (3) | <input type="checkbox"/> Other (8) |
| <input type="checkbox"/> Day Care Provider (4) | |
| <input type="checkbox"/> All of the above (6) | |

from the designated record set of _____ whose birth date is _____
(Patient's Name)

The following information shall be released (mark all applicable):

- Hemoglobin
 Immunizations
 Lead Screening
 TB Tests

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provide by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information is effective today until the termination date of: _____
(Date)

Signature: _____ Date: _____

If you are the personal representative, please specify your relationship to the patient: _____