AUTHORIZATION FOR RELEASE OF INFORMATION

NOTE: All matters relating to the physical or mental condition of patients are considered privileged and confidential and are treated as such by the employees of the institutions, information regarding such matters cannot be given without the consent of the patient, or if he is adjudged incompetent, the written permission of his guardian or nearest relative must be obtained. (See section 2317.02, R.C.)

The Athens City-County Health Department
278 West Union Street, Athens, Ohio 45701
740-592-4431

is hereby granted my permission to release to the following:

Organizations/Individual(s) Name ______________________________

Street Address ______________________________

City/Town ________________ **State** ____________ **Zip Code** __________

Fax Number ________________ **Phone Number** ________________

Patient Information

First ____________ **Middle** ____________ **Last** ____________

Date of Birth ________________

Street Address ______________________________

Town/City ________________ **State** ____________ **Zip Code** ______

IS THE PATIENT A MINOR OR DEPENDENT ADULT? YES NO

DATE RELEASE SIGNED: ________________

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SIGNATURE OF PATIENT, GUARDIAN/LEGAL REPRESENTATIVE:

"Guardian/Legal Representative" is the individual who has legal authority to have the Patient's Medical Records released.

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WITNESS