Authorization to Release/Obtain Medical Records

Patient First Name :

Patient Last Name :

Patient DOB:

I am requesting to obtain medical records for myself or my child. I do hereby state that I am the patient or the parent and or/legal guardian of the patient listed above. **By signing below, I request/authorize Hancock Public Health (HPH) to obtain/disclose my or my child's 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 below. This authorization may not be revoked where HPH has acted in reliance on the authorization. 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.

This authorization expires 1 year from the date of signature listed below.

Patient/Parent/Legal Guardian Name and Relationship to Patient: _____

Patient/Parent/Legal Guardian Signature and Date: _____

Party Receiving Request (HPH Employee):