LaSalle County Health Department
Authorization for Release of Protected Health Information

I,_____, hereby authorize LaSalle County Health Department
Name of client or Personal Representative

To release the information listed below to:
To obtain the information listed below from:

_____
Name of person to receive/release information

_____ _____ _____ _____
Street Address City State Zip

From the designated record set of_____DOB: _____
Name of client

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

- ☐ Child health exam
- ☐ Blood lead testing results
- ☐ Family planning records
- ☐ TB care and treatment records
- ☐ STD testing and treatment records
- ☐ HIV records
- ☐ Laboratory results (specify) _____
- ☐ Immunization records
- ☐ Other (specify) _____

The purpose of this authorization is:

- ☐ At the request of the Individual or personal representative
- ☐ For referral to another health care provider
- ☐ Other (specify)_____

The information should be released for the following time period: _____ to_____

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 provided 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 tore-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed above, or until I revoke it in writing by delivering a written revocation notice to the health department.

_____ _____
Signature Date

_____
Client representative-please specify relationship above

For health department use only:

_____ _____
Staff signature Date