

NODAWAY COUNTY HEALTH CENTER
2416 South Main
Maryville, MO 64468
(660) 562-2755 phone (660) 562-4995 fax

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date _____

_____ I would like to receive a copy of the immunization record of

Name _____ Date of Birth _____

Legal Representative Relationship to the person for which you are requesting the immunization record _____ Self _____ Parent (We cannot provide records of someone aged 18 and over without their written permission)

Or

_____ I would like for a copy of this immunization record to be sent to

Name of person/organization: _____

Address _____

City _____ State _____ Zip _____

Purpose of this request: ___Personal Use ___School ___Other

I understand that

- 1) I need to provide proof of identity.
- 2) If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment
- 3) I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of
- 4) I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to Nodaway County Health Center, 2416 South Main, Maryville, MO 64468
- 5) If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation
- 6) I have a right to receive a copy of this authorization
- 7) Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA).
- 8) I release Nodaway County Health Center and its employees and volunteers from all liability arising from the disclosure of my health information pursuant to this agreement.
- 9) Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire one year from the date hereof, unless specified: _____

Signature _____

(Patient or Legal Representative)

Copy of photo ID required