

Consent/Authorization to Use & Disclose Health Information

Putnam County Health Department
256 Williamstown Road, PO box 330
Ottawa, OH 45875
419-523-5608

Patient Name: _____ Birth Date: _____

Consent

By signing this consent, I authorize the Putnam County Health Department to use and/or disclose my health information for (1) treatment, (2) payment or (3) health care operations. I have the right not to sign this consent; however, if I refuse to sign this consent, the Putnam County Health Department has the right to refuse to treat me.

My rights with respect to consent include: (1) to receive a paper copy of our Notice of Privacy Practices prior to signing the consent, (2) to request restrictions on the uses and disclosures of health information, (3) the right to revoke the consent at anytime except to the extent that we have already taken certain actions based on the consent prior to revoking it, (4) the right to receive a copy of this consent form after you sign it.

This consent is effective unless and until I revoke it in writing.

I hereby authorize the Putnam County Health Department to use and/or disclose my health information for treatment, payment, or health care operations.

Patient Signature (Guardian or Health Care Power of Attorney)

Date

Witness

Authorization

By signing this authorization form, I authorize the Putnam County Health Department to use and/or disclose my health information in the manner described below. I understand that I am under no obligation to sign this authorization form and that the Putnam County Health Department who I am authorizing to use and/or disclose my information may not condition treatment, payment, or enrollment for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the health information described below.

I authorize the following health information to be used and/or disclosed: (give description)

I authorize the following organization (or person) _____

to receive my listed health information above from the Putnam County Health Department. I understand that if the organization (or person) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed in this authorization may no longer be protected by the federal privacy standards and such organizations (person) may redisclose my health information without obtaining my authorization.

Your rights with respect to authorization include: (1) the right to revoke or restrict the authorization, in writing (see HIPAA policy attachment #6A) at anytime except to the extent that we have already taken certain actions based on the authorization prior to revoking it, (2) the right to inspect or copy the health information to be used or disclosed, (3) the right to receive a copy of this authorization.

I have had an opportunity to review and understand the contents of this authorization form. By signing this form, I am confirming that it accurately reflects my wishes.

This authorization will expire on _____ (insert date)

Patient Signature (Guardian or Health Care Power of Attorney)

Date

Witness

Permiso/Autorización de Usar & Revelar Información de Sanidad

Departamento de Sanidad del Condado de Putnam
 256 Williamstown Road, P.O. Box 330
 Ottawa, Ohio 45875
 Teléfono: 419-523-5608

Nombre del Cliente: _____

Fecha de Nacimiento: _____

Permiso

Al firmar éste permiso, yo autorizo al Departamento de Sanidad del Condado de Putnam de usar y/o de revelar información de mí salud para (1) tratamiento, (2) pago, o (3) funcionamiento de sanidad. Tengo el derecho de no firmar éste permiso, sin embargo, si yo me niego firmar éste permiso, el Departamento de Sanidad del Condado de Putnam tiene el derecho de negarme el tratamiento.

Mis derechos con respeto al permiso incluye: (1) recibir una copia de nuestra Noticia de Privado/Confidencia, (2) pedir restricciones en los usos y revelaciones de información de salud, (3) el derecho de revocar/quebrantar el permiso en cualquier tiempo excepto hasta el punto que ya hemos tomado ciertas acciones bajo el permiso antes de revocarlo/quebrantarlo, (4) el derecho de recibir una copia de ésta hoja de permiso después de la signatura/firma.

Éste permiso es efecto a no ser, o hasta que yo lo revoque o quebrante en escrito.

Por las presentes autorizo al Departamento de Sanidad del Condado de Putnam a que use/o revele información de mi salud para tratamiento, pago, o funcionamiento de sanidad.

 Signatura/firma del cliente (Guardian o Procuración/Poderes Legales)

 Fecha

 Testigo

 Fecha

PCHD Original: 5/03

Nuestras instalaciones no son accesibles totalmente perjudicado. Si usted tiene una necesidad especial, llame por favor el Departamento de la Salud del Condado de Putnam para la información en 419-523-5608, y acomodaremos esa necesidad.