



Barren River District Health Department

“Serving Barren, Butler, Edmonson, Hart, Logan,
Metcalfe, Simpson, and Warren Counties”

Authorization for Release of Patient Information	
<i>The undersigned hereby authorizes the Barren River District Health Department to release to:</i>	
Name:	
Address:	
Phone: ()	Fax: ()
Do you want this information faxed or sent by mail?	
<i>Information from the patient record of:</i>	
Name:	
Date of Birth:	Social Security Number:
Type and dates of information being requested (ex: Family Planning records for previous year, immunization record, etc.):	
<i>The recipient of the referral agrees to abide by the rules and regulation regarding the confidentiality of personal medical records as mandated by the Health Insurance Portability and Accountability Act (HIPPA) (42USC1320D) and set forth in federal regulations at 45 CRF part 160 and 164.</i>	
It is understood that this authorization is subject to revocation at anytime and that unless another date is specified will expire sixty (60) days after the date signed. The Local Health Department, facility designed above, their employees and officers are leased from legal responsibility for release of the information specified above.	
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Signature of Client/Patient, Parent or Legal Guardian	Date:
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Relationship (if signature is not patient/client)	
<i>This information is to be held in confidence and is non-transferable.</i>	