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Bryant Wilke, R.S., M.P.H., Health Officer
Mustafa Mark Hamed, M.D., M.P.H., Medical Director

SCHD Sanilac County Health Department

'Protecting and promoting health for Sanilac County citizens since 1937'

AUTHORIZATION TO RELEASE INFORMATION

Client's Name: _____

Date of Birth: _____

I hereby authorize Sanilac County Health Department to (check one):

___ obtain information from the following physician/facility _____

___ release information to the following physician/facility _____

The documents to be released are described or listed as: _____

_____

_____

The records are required for the specific purpose of: _____

_____

I understand that my authorization will remain effective from the date of my signature until one (1) year from that date. Client records are protected by Federal law and regulations (42 CFR Part 2). Generally, this means that information about you is not disclosed without your written consent.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written and dated communication.

I have read and understand the nature of this release.

_____

Signature of Client/Client's Designated Representative Date

_____

Witness Signature Date