NEW CASTLE COUNTY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name of person whose health information will be disclosed:** *[please print]*

Part 2: **Person or Entity that has the health information to be released:**

❒ New Castle County
❒ New Castle County Employee Health Care Plan *(as defined in New Castle County's Privacy Policy)*
❒ Other: _____ *[please print the name of the entity that has the record to be disclosed; e.g., Dr. Jane Doe, XYZ Insurance Company, ABC Laboratories, etc.]*

Part 3: **Description of the health information to be released:**

❒ Lab results (including drug screening and blood-alcohol test results)
❒ Psychiatric/psychological evaluation
❒ Physical examination results and notes
❒ History, treatment and progress notes
❒ Other: _____ *[describe the health information that may be disclosed]*

Are the records to be released limited to records created during a **specific period of time:** ❒ No ❒ Yes
If "Yes" indicate specific time period: From *[insert date]* to *[insert date]*

Part 4: **Person or Entity that will receive the health information:**

❒ New Castle County
❒ New Castle County Employee Health Care Plan *(as defined in New Castle County's Privacy Policy)*
❒ Other: *[please print the name of the entity that will receive the record]*:

Part 5: **Description of the purpose for the release of the health information:**

❒ At the request of the person whose name appears in Box 1
❒ Pre-employment or periodic controlled substance screen or psychoanalysis evaluation
❒ Other *[insert description of the purpose]*:

Part 6: **Duration of Authorization:**

This Authorization will remain effective *[choose an expiration period or event]*:

Expiration period: ❒ 30 days ❒ 60 days ❒ 90 days ❒ 180 days ❒ ___ days

Expiration event: *[insert description of an event upon which the Authorization will expire]*:

Part 7: **Certification and Acknowledgement:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 5 for the purpose(s) designated in Part 6. ***I understand that, if the information to be disclosed is needed by a health care plan in order to determine my eligibility for plan benefits; or is needed by New Castle County to consider me for medical, sick or other leave; or to consider my eligibility or claim for short- or long-term disability or life insurance coverage or benefits, workers' compensation benefits, or similar fringe benefits; or to consider me for employment or continued employment, my failure to provide this Authorization may prevent me from receiving the benefit or leave, or preclude me from being considered for employment or continued employment.*** I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity who received the Authorization, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. ***I have received a copy of my signed Authorization.***

Signature: _____ **Date:** _____

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:
Name: _____ Authority: _____

For office use:
❒ Authorization fully completed and signed
❒ Copy of Authorization provided to Individual or Personal Representative