HIPAA Release Authorization

Health Insurance Portability and Accountability Act (HIPAA)

Authorization for Release of Protected Health Information

Patient Name: ____

Birth Date: ____

Street: ____

City, State, Zip Code: ____

I, ____, hereby give permission to the Polk County Health Department, its employees, and representatives to disclose information for the purpose of the lead remediation / home repair program to:

Polk County Health Department

Only the following information will be disclosed:

Blood Lead Levels

Signature: ____ Date: _______________
Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____________________________

This authorization is effective for no longer than 1 year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Chief Privacy Officer at Polk County Health Department.