CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Authorization to Disclose Health Information

Name _____

Date of Birth_____

I, _____ hereby authorize the Cuyahoga County Board of
(Client, Patient or Personal Representative)
Health to disclose specific and identifiable health information from the records of the above named person to
(Recipient Name/Address/Phone/Fax):

_____

_____

_____

For the specific purpose(s) of:
Personal Use
_____

_____

Specific information to be disclosed:
COVID-19 Vaccine Card/Record
_____

_____

This authorization will expire on the following date, event or condition:
One-time authorization
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time. I further understand that any action taken by the Cuyahoga County Board of Health in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client/Patient)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*

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NOTE: This Authorization was revoked on:

_____	_____
(Date)	*(Signature of Staff)*