ASHTABULA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, the below identified person, do hereby authorize the release of the following protected health information (PHI) to the following organization:

Individual's Name _____ DOB _____

Address _____

Organization authorized to receive/release information

Organization: Ashtabula County Board of Developmental Disabilities

Department:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Person or Healthcare Provider authorized to release/receive information

Person/Healthcare Provider:_____

Department:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Records authorized to be released

□ Social History	□ Psychological Assessments	□ Financial Information
□ Vocational Evaluations Information	□ Habilitative Information	□ Educational Information
□ Medical Records	□ Dental Records	□ Other

Extent or nature of records to be released and dates:_____
_____

This information will be used for the purpose of

□ Verifying my eligibility for services
□ Coordination of services
□ Other activities at my request
_____

This authorization will expire on _____.

I understand that I can revoke this authorization at any time by writing to the healthcare provider or to the Ashtabula County Board of Developmental Disabilities, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Ashtabula County Board of Developmental Disabilities may re-disclose the information.
- I am entitled to receive a copy of this authorization
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Individual or Representative Date

_____ _____
Printed Name of Individual or Representative Relationship to Individual