Crawford County Job & Family Services
224 Norton Way
Bucyrus, Ohio 44820
Telephone 419-562-8066
Fax 419-562-7970

Authorization for the Release or Use of Protected Health Information (PHI)

Name:	**Address:**
Billing Number:	
Social Security Number: (Optional –see reverse side)	

I, _____ hereby authorize _____ to disclose protected
(Name of individual) (Name of covered entity, such as "Physician")

health information to **Crawford County Job and Family Services** for the purpose of **attendance of appointment**.

_____
(Describe why this information is being released)

Information is to be mailed to Street: **224 Norton Way** City: **Bucyrus** State: **Ohio** Zip Code: **44820**

Is this information being released for an insurance claim? _**X**___ NO ___YES (if YES, see Section II on reverse side)

SECTION B:

The specific protected health information to be released is: **Date, Time and Proof of Attendance to Appointment.**
_____

SECTION C: By signing below, I understand that:

- This authorization shall expire on **Indefinitely** or until revoked by me in writing, whichever comes first.
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to: (insert CDJFS address)
  Crawford County Job and Family Services, 224 Norton Way, Bucyrus, Ohio 44820
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- I am not required to sign this authorization. If I refuse to sign this form, it will not affect my Medicaid eligibility my eligibility for other programs such as Disability Assistance Medical, Refugee Medical, or Healthy Start/Healthy Families or my application for such programs.
- I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
- If by law we cannot send the protected health information to the entity listed above, please initial in the following space if you want a copy of the information sent to you directly: _____ .

_____

SECTION D:

Signature of Individual or Authorized Representative **Print name of individual/Date**

Representative's legal authority to individual Print name of Authorized Representative/Date

*** Important Information and Instructions for completing this form are on the reverse side***