113 Harding Way East
Galion, Ohio 44833

Phone 419.468.1075
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Authorization to Disclose Information

Name of Patient: ___________________________ Date of Birth: ______________

I, ___________________________, as the patient or parent/guardian of the above named patient, hereby authorize the Galion City Health Department to disclose records of the above named patient to and/or receive records from the below entities for the specific purpose of presenting written evidence.

- ☐ Any Physician ☐ Any School ☐ Any WIC ☐ Any Head Start
- ☐ Any Public Agency ☐ Any Health Department ☐ Children with Medical Handicaps
- ☐ Other (List): ___________________________
- ☐ None

Description of Information to be Released:

- ☐ Immunization Records

This authorization will expire upon the presentation of written evidence sufficient to comply with Section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* at the bottom of this form. I further understand that any action taken by the above-named provider(s) 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 requestor of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that my refusal to sign this authorization may prevent a school from verifying that the above-named patient has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above-named patient has been immunized, the patient may be excluded from school pursuant to Section 3313.671 of the Ohio Revised Code.

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

___________________________ ______________ ______________

Signature of Patient or Parent/Guardian Date Relationship

This authorization was revoked on: ______________ ___________________________

Date Signature of Staff Member

Rev. 06/14/2018