Jefferson County
PUBLIC HEALTH SERVICE

Public Health Facility, 531 Meade Street, Watertown, New York 13601

Patient Name: _____ Date: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. It authorizes Jefferson County Public Health Service to use/disclose my immunization records to _____ _____ for the purpose(s) of _____ _____. This authorization is valid until _____ (date). The person/people authorized to make this use/disclosure is/are _____ _____.

Under the Privacy Rules, I have the right to revoke this authorization at any time, and Jefferson County Public Health Service must cease using this authorization. However, Jefferson County Public Health Service may complete any actions it initiated prior to my revocation and which rely on my immunization records for completion.

I understand that by disclosing my immunization records, Jefferson County Public Health Service cannot guarantee the recipient will use or disclose in violation of the Privacy Rules.

I must revoke this authorization in writing and send the revocation to Jefferson County Public Health Service.

Please type or print name: _____

Signature: _____

Date: _____

Or
Copy of Health Care Proxy required naming personal representative as health care agent.
Personal representative: _____

Signature: _____

Date: _____

11/20/13
GH:blp
Phnadmin/bridget/forms/authorization of use