If you would like a copy of your immunization record, please use the Authorization to release record form. This can be returned to the nursing department during normal business hours. You will be asked to present your I.D. and custody papers if applicable.

- Please note that if you are 18 or older you must be the one to fill out the authorization to release record form, and present your I.D.
AUTHORIZATION TO RELEASE RECORDS OF INDIVIDUAL OTHER THAN
PARENT/GUARDIAN OR PATIENT

I hereby ( ) request ( ) authorize Hancock Public Health (HPH) to ( ) obtain ( ) disclose my individually
identifiable health information as described below. I understand that this authorization is voluntary and that
I may revoke the authorization in writing addressed to the Privacy Officer at the address above. This
authorization may not be revoked where HPH has reasonable acted in reliance hereupon.

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the
recipient and no longer protected by federal privacy regulations.

I, _______________________________ (must show copy of I.D.) am the patient, or
parent/legal guardian of _______________________________, born ___________________ and
am providing signed consent to release the following records of the patient to
_________________________________________ (Must provide copy of I.D. @ time of release)

Relationship to patient: __________________________________________________________

This authorization is effective from ______________________ to ______________________
• NOT to exceed 1 year

PRINT Patient/Parent or Legal Guardian Name: _______________________________________

Signature of Patient/Parent or Legal Guardian ________________________________________

Description of information being disclosed:

□ Complete Health Record       □ Immunization Record       □ TB Test Results

□ Consultation Reports         □ Nurses Notes             □ Laboratory Tests

□ BCMH Records

Other: ________________________________________________________________________

Party receiving this request: _______________________________________________________

(Hancock Public Health/ Employee’s name)

Additional information can be found in the Notice of Privacy Practices.
- PROVIDE COPY TO INDIVIDUAL AND ORIGINAL TO FILE –