



# AUTHORIZATION FOR RELEASE OF INFORMATION

## FRANKLIN COUNTY PUBLIC SAFETY

(FORM MUST BE FULLY COMPLETED)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this Authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient's Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Persons/organizations providing the information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Persons/organizations receiving the information:**  
FRANKLIN COUNTY PUBLIC SAFETY  
1488 Franklin Street, P O Box 189  
Rocky Mount, Virginia 24151

**Specific description of information (including date[s]):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The patient or the patient's representative must read and initial the following statements:**

1. I understand that this authorization will expire (give date or event) \_\_\_\_\_. Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying Franklin County Public Safety, Post Office Box 189, Rocky Mount, Virginia, 24151, in writing; but if I do, it won't have any effect on any actions they took before they received the revocation. Initials: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_  
**Signature of patient or patient's parent/guardian**  
(Form MUST be completed before signing)

**Printed name of patient's parent/guardian:** \_\_\_\_\_

**Relationship to the patient:** \_\_\_\_\_

**\* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION \***  
*You may not use this form to release information for treatment or payment  
except when the information to be released is psychotherapy notes or certain research information*

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## **ACKNOWLEDGEMENT**

State of \_\_\_\_\_

City of \_\_\_\_\_

The foregoing instrument was acknowledged before me by \_\_\_\_\_ this  
(name of patient or patient's representative)

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_[SEAL]  
Notary Public

My commission expires: \_\_\_\_\_