

**Polk County Board of County Commissioners  
Authorization to Release  
Protected Health Information (PHI)**

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By signing this Authorization to Release Protected Health Information, I authorize the Polk County Board of County Commissioners to use and/or disclose certain PHI about me to or for the parties listed below.

This Authorization permits Polk County Board of County Commissioners to use or disclose the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

This Authorization will expire on \_\_\_\_\_.

When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this Authorization in writing except to the extent that Polk County Board of County Commissioners has acted in reliance upon this Authorization. My written revocation must be submitted in writing to the Privacy Officer in the unit that provides/d my services.

Signed by: \_\_\_\_\_  
Signature of Patient/Client or Legal Guardian      Relationship to Patient/Client

\_\_\_\_\_  
Patient/Client's Name      Date

\_\_\_\_\_  
Print Name of Patient/Client or Legal Guardian