

Authorization for Records Release

I hereby give consent for Clinton County Health Department [CCHD] staff to release and exchange information concerning myself, my family, and/or my child with potential service providers and other professionals [named below] who may be of service to us.

I understand that all such information will be treated as **CONFIDENTIAL AND PRIVILEGED**. I also agree that a photocopy of this original authorization may be used instead of the original and is valid until rescinded by me.

I give permission to the CCHD to bill Medicaid or other insurance companies on my behalf. Services performed by other providers will **not** be covered by CCHD unless expressly stated.

I hereby authorize release of my personal health related information to the following providers and/or agencies:

Department of Social Services

WIC

CVPH

Doctor's Office

Early Advantages

Project Gabriel

Behavioral Health Services North

Clinton Mental Health

Partner's Name

Northern Adirondack Planned Parenthood

Signature/Relationship (parent must sign for child)

Witness/Title

Date