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/discard 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: ____________________________