The Anglican Diocese of the Great Lakes
3810 Ridgewood Road, Copley, OH 44321

HIPPA Release of Information
AUTHORIZATION FORM

I, (Name) _____ hereby authorize (facilitator)_____ and
Its affiliates, its employees and agents (collectively (agency) _____), to release to
The Anglican Diocese of the Great Lakes **[Insert full name of person/organization]** my personal health information maintained by(person / agency) _____ (e.g., information relating to the diagnosis, and health care information provided or to be provided to me and which identifies my name, address, social security number, **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the following reason(s). I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire in one year from date of signing.

I understand that I have a right to revoke this authorization by providing written notice to The Rev. Canon Andrea Orchard. However, this authorization may not be revoked if Anglican Diocese of the Great Lakes, or its agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. *Refusal to sign will require the Bishop's Godly determination/consultation*.

Printed Name: _____

Signature: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Date: _____

The Rev. Canon Andrea Orchard aorchard@adgl.us 234-466-0426