New Philadelphia City Health District

150 E. High Avenue, St 011, New Philadelphia, OH 44663 ☎ 330.364.4491 ext. 1208

https://www.newphiladelphiaoh.gov/170/Health-Department 330.364.8830

Release of Patient Information Authorization Form

Patient Name_____ Date_____

Date of Birth_____ Telephone Number_____

Address_____

City_____ State_____ Zip Code_____

To provide continuity of care, I hereby authorize

- ☐ New Philadelphia City Health Department
- ☐ Other _____

To release pertinent medical information related to this case to

- ☐ New Philadelphia City Health Department
- ☐ Other_____

Print Name_____ Relationship to Patient_____

Signature_____ Date_____

Witness Signature (if applicable)_____ Date_____

Health Department Use only

Records Requested:

- ☐ Immunization Records
- ☐ Clinic Visit Notes
- ☐ Other_____
- ☐ Identification verified at pick up

Authorization and consent will expire six months from the date of authorization unless revoked by the patent or legal representative through written notice. Any revocation does not apply to information that has been previously released in response to this authorization.

DF 12/01/2025