ONONDAGA COUNTY HEALTH DEPARTMENT
Lead Poisoning Control Program
421 Montgomery Street, 9th Floor
Syracuse, New York 13202
Phone: (315) 435-3271
Fax: (315) 435-3720

Authorization for Use or Disclosure of Individually Identifiable Health Information

Name of (Client/Patient/Child)	DOB	SS#	(Other)

I allow the ONONDAGA COUNTY HEALTH DEPARTMENT to:

RELEASE TO: __X__ OBTAIN FROM: _____	RELEASE TO: ____ OBTAIN FROM: ____
Department of Community Development	
City of Syracuse Lead Program	
201 E. Washington St., Room 500, Syracuse, NY 13202	
The following information:	The following information:
Results of all blood lead tests performed from the	
date of child's birth until the expiration date of this	
authorization (one year from the date it is signed).	
Reason:	Reason:
To use as criteria for accepting my family into	
the City of Syracuse Lead Program	

I understand that I can take back this permission unless the information has already been given out. To take back the permission, I must send a letter to the Health Department program listed at the top of this page. Any records given out using this signed permission may be sent somewhere else by the agency we give it to. If they send it on, it may not be protected by the same laws.

You will not be refused any care by the Onondaga County Health Department if you decide not to sign this form. The line below lists anything that will not be given out.

_____

I understand that a copy of this can be used the same way as this form.

This permission ends One Year from the date signed by the (client/patient/parent/guardian).

(Client/Patient/Parent/Guardian)	Witness
Relationship to (Client/Patient/Child) Date	Date