

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: (Please Print) DOB: (mm/dd/yyyy)

Previous Name:

I authorize the Whiteside County Health Department/Whiteside County Community Health Clinic (WCHD/WCCHC) to:

[X] Disclose to, or [X] Obtain from

Former Treatment Provider:

(Name/Title of Person or Agency, address, phone)

The following information shall be Disclosed and or Obtained:

[X] Entire Medical Record - note separate box below is also required for HIV, psychiatric, and substance abuse access.

[] Other - Specific information (office visit, labs, x-rays, etc.)

I authorize WCHD/WCCHC to release or obtain the selected highly confidential health information by initialing below:
[X] Mental Health Treatment Records
[X] HIV/AIDS/STD Records
[X] Alcohol, Drug, or Substance Abuse
Initials:

This release applies to information from the following time period: from ___/___/___ to ___/___/___

The purpose of this authorization is: [X] At the request of the Individual or Personal Representative
[] Other:

I understand that I have the right to revoke this authorization by giving written notice to WCHD/WCCHC. I understand that if the WCHD/WCCHC has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization.

I understand this authorization is voluntary and WCHD/WCCHC may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below or until I revoke it in writing by delivering a written revocation to WCHD/WCCHC.

I have a right to inspect and copy the information contained in my medical record. I am entitled to a copy of this authorization if WCHD/WCCHC is seeking the authorization.

The authorization for release of protected health information terminates on ___/___/___ . If no expiration date, event, or condition is given, this authorization expires in 1 year from date of the request.

[X] Date
Patient Signature (includes children age 12 to 18; Behavioral Health or Family Planning)
If you are not the patient, please indicate your authority to represent individual
[] Parent [] Guardian [] Power of Attorney [] Personal Representative [] Legal Representative

Witness Signature: Date

REVOCACTION SECTION: I revoke my authorization to release healthcare information:

X Date

Patient Signature (includes children age 12 to 18; Behavioral Health or Family Planning)