WHITESIDE COUNTY HEALTH DEPARTMENT

Whiteside County Health Department | Whiteside County Community Health Clinic
1300 West 2nd st., Rock Falls, IL 61071 PHONE: (815) 626-2230
MEDICAL FAX: (815) 632-4558 | DENTAL FAX: (815) 626-6339 | BEHAVIORAL HEALTH FAX (815) 380-2056

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

I authorize the Whiteside County Health Department/Whiteside County Community Health Clinic (WCHD/WCCHC) to:
☒ Disclose to, or ☒ Obtain from

_____
(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. If I refuse to sign this authorization, the above described health information will not be disclosed except as provided by law.

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_____

REVOCATION SECTION: I revoke my authorization to release healthcare information:
X_____Date_____
Patient Signature (includes children age 12 to 18; Behavioral Health or Family Planning)