

2515 STATE STREET
CHESTER, IL 62233-1149
PHONE: (618) 826-5007
FAX: (618) 826-5223



Clinic Site:
211 NORTH HASLE STREET
612 EAST MORTON STREET
SPARTA, IL 62286

PHONE: (618) 443-2995

FAX: (618) 443-6960

Authorization Form for Release of Protected Health Information

I, _____ hereby authorize the Randolph County Health Department

(Name of Patient or Personal Representative)

to release the information listed below to:

to obtain the information listed below from:

Name of Person to Receive/Release Information

(Street Address)

(City)

(State)

(Zip)

from the designated record set of _____ whose birth date is _____
(Patient's Name)

The following information shall be released (mark all applicable):

- Child Health Exam
- Blood Lead Test Results
- TB Care & Treatment Records
- STD Testing and/or Treatment Records
- HIV/AIDS Records
- Laboratory Reports (Specify _____)
- X-Ray or Other Photographic Reports
- Immunization Records
- Other:(Specify _____)

The purpose of the authorization is:

- at the request of the individual or personal representative
- for referral to health care provider
- Other:_____.

The information should be released for the following time period: from _____ to _____

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department 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 provide by law.

I understand that the health department 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 subject 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 the health department.

Signature_____

Date_____

If you are the personal representative of the patient, please specify your relationship to the patient:_____

07/09

Staff signature _____

Date _____