Community Health Care, Inc.
Opening Doors to Health Care

For Same Day Release: I have verified the identity of the patient and received photo ID
Initials_____Date:_____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

☐ CHC-Moline ☐ CHC-Rock Island ☐CHC-Dental ☐CHC-River Drive ☐CHC-East Moline ☐CHC-Clinton ☐CHC-Edgerton ☐CHC-Muscatine

Patient Name _____ **Chart #** _____

Date of Birth _____

Information to be released from:

Name/Agency: _____

Address: _____

City/State/Zip _____

Phone: _____ Fax: _____

Send requested medical information to:

Name/Agency: _____

Address: _____

City/State/Zip _____

Phone: _____ Fax: _____

Information requested for Service Dates _____ **to** _____

□Consults/Referrals	□ ER/Hospital	□ Radiology Reports
□ Progress Notes	□ Lab Results	□ Immunization Records
□ Other_____		

Please check any items that you **DO NOT** want us to send. If left unchecked records will be sent.

☐ Sexually Transmitted Disease ☐Mental Health ☐ (drug/alcohol) ☐ HIV/Aids ☐Genetic Testing ☐Infectious Disease

☐ Reproductive Health Records (contraception, preconception screening and counseling, pregnancy, prenatal care, miscarriage, pregnancy termination, fertility and infertility diagnosis and treatment, and treatment of conditions that affect the reproductive system.

This information is required for:

☐ Transfer of care ☐ Personal Copy ☐ Consultation/Referral ☐ Dissatisfaction with the clinic, please specify:_____

How would you prefer to receive your records: ☐ Paper Records ☐ CD

- I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked. I understand that this release is valid for one year from the day it was signed or on_____ , and I may refuse to sign this authorization or cancel this authorization at any time. If I cancel or don't sign, it will not stop me from being seen at Community Health Care. The cancellation will take effect on the day a signed copy is received by Community Health Care. I have a right to my treatment records. Copies of my records will be given to me with advanced notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that the information may be sent again and no longer protected.
  No medical records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirement (42 CFR Part 2) prohibit further disclosure without the specific written consent of the patient.

Patient Signature _____ **Date** _____

Signature of Representative _____ **Date:** _____

Witness Signature _____ **Date:** _____

Authority to represent individual: ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Authorized Representative**