



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

Patient Name _____ Chart # _____
 Date of Birth _____

Information to be released from:

Send requested medical information to:

Name/Agency: _____

Name/Agency: _____

Address: _____

Address: _____

City/State/Zip _____

City/State/Zip _____

Phone: _____ Fax: _____

Phone: _____ Fax: _____

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

| | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Consults/Referrals | <input type="checkbox"/> ER/Hospital | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> 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

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