

**Authorization to Disclose Health Information**

I hereby authorize Sparta Community Hospital District and entities d/b/a  
818 E Broadway, PO Box 297, Sparta, IL 62286 – 618-443-2177 x1449 – Fax: 618-443-1380

to disclose my individually identifiable health information as described below.

\_\_\_\_\_  
Patient Name DOB/SSN MR#

Name/Address of person(s) or organization(s) to receive the records:  
\_\_\_\_\_  
\_\_\_\_\_

From the following date(s): \_\_\_\_\_

For the purpose of  continued medical care  workman's compensation  
 payment of medical balances  legal action  
 at the request of the individual  Other \_\_\_\_\_

Please mark (x) the specific information to be disclosed:

_____ Discharge Summary/Resume	_____ History & Physical	_____ Consultations
_____ Operative Report	_____ Pathology Report	_____ Lab Reports
_____ Radiology Reports	_____ EKGs	_____ Therapy Notes
_____ Physician Progress Notes	_____ Emergency Room Report	_____ Entire Record
_____ Films _____	_____ Itemized Statement	_____ Clinic Records
_____ Accounting of Disclosure for dates: _____		
_____ Other: _____		

Understandings and Agreements of Requestor:

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. This authorization will expire based on the following date, event or condition: \_\_\_\_\_  
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.
4. This authorization is voluntary and treatment at this facility is not contingent on signing this authorization.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by this facility.
6. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records which has been set by Illinois law. Fees subject to annual adjustments.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
Relationship of Legal Representative Witness

Office Use Only

Records released by: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_