Authorization to Disclose Health Information

I hereby authorize: SPARTA COMMUNITY HOSPITAL DISTRICT - QUALITY HEALTHCARE CLINICS

___ ***Bradbury Surgical***
211 South Burns Avenue
Sparta, IL 62286

___ ***Convenient Care***
1300 North Market Street
Sparta, IL 62286

___ ***Coulterville Medical Clinic***
P.O. Box 485
Coulterville, IL 62237

___ ***Family Health Centre & Specialty Clinic***
207 South Burns Avenue
Sparta, IL 62286
Family Practice ___ Specialty ___

___ ***Marissa Medical Clinic***
521C North Borders
Marissa, IL 62257

___ ***Northtown Clinic***
1300 North Market
Sparta, IL 62286

___ ***Sparta Medical Office***
215 A/B South Burns Ave
Sparta, IL 62286
FP___ Urology___

___ ***Steeleville Clinic***
9 Westwood Drive
Steeleville, IL 62289

to disclose my individually identifiable health information as described below.

_____

Patient Name DOB SS#

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

_____

_____

From the following date(s):_____to: _____

For the purpose of
☐ continued medical care ☐ workman's compensation ☐ transfer to new Physician
☐ payment of medical balances ☐ legal action ☐ reason _____
☐ at the request of the individual ☐ Other_____ _____

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

_____ Encounter/Visit Note _____ Lab Report _____ Radiology Report
_____ Immunizations _____ Pathology Report _____ EKG
_____ Med List _____ Itemized Statement
_____ Problem List _____ Hospital Records: DS/HP/OP note/ER Note _____ Entire Record
_____ 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. (_____initials required to release this information)
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 are subject to annual adjustments.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship of Legal Representative Witness

Office Use Only

Records released by:_____Date_____Time_____