

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Sparta Community Hospital District and entities d/b/a

818 E. Broadway, PO Box 297, Sparta, IL 62286

Phone: 618-443-2177 x3336 | Fax: 618-443-1380

Patient Information

Patient Name	Date of Birth
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Authorized Recipient

Name / Organization: _____

Address: _____

Fax #: _____ Phone #: _____

Information to Be Disclosed

Dates of Service: _____

- Discharge Summary History & Physical Operative Reports Progress Notes Lab / Pathology
 Imaging Reports Imaging Pictures Emergency Dept. Therapy Notes Consultations
 Clinic Records Immunizations Billing Statements Entire Record
 Other: _____

Purpose

- Continuity of care At the request of the individual Payment / Insurance Legal
 Other: _____

Special Consents Required by Law: initial if we may release these specific types of records.

Mental Health / Developmental Disability Records (740 ILCS 110): **Initials:** _____

HIV / AIDS Information (410 ILCS 305): **Initials:** _____

Substance Use Disorder Records (42 CFR Part 2): **Initials:** _____

42 CFR Part 2 Redislosure Notice

This information is protected by federal confidentiality rules (42 CFR Part 2). The recipient may not redisclose this information unless permitted by federal law. This information may not be used to initiate or substantiate legal proceedings against the patient without a court order.



