Authorization for Use / Disclosure (Receipt / Release) of Protected Health Information

I hereby authorize the use and disclosure of protected health information about me as described below.

_____ _____ _____

Patient's Name - PLEASE PRINT | Maiden / Other names used | Patient's Date of Birth

_____

Patient's Street Address City State Zip Code Home Phone Work/Cell Phone

Records Requested FROM:	**Address**	**City, State Zip Code**	**Phone Number**	**Fax Number**
❒ **Cass County Health Clinic (Physician Clinic)**	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7814
	8590 St. Luke's Dr.	Beardstown, IL 62618	P:217-323-2242	F:217-323-2210
❒ **Cass County Public Health**	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7245
	110 East Main	Beardstown, IL 62618	P:217-323-2182	F:217-323-2196
❒ **Cass Co Home Health/Cass Schuyler Area Hospice**	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7245
❒ **Cass County Dental Clinic**	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7814
❒ **OTHER:**				

Send Records TO:	**Address**	**City, State Zip Code**	**Phone Number**	**Fax Number**
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❒ **OTHER:**				

1. **Specific description of information to be used/disclosed:** ❒Medical Record (last 24 months will be sent if not specified) OR Dates from: _____to_____ ❒Other- _____
2. **The information may be used or disclosed for each of the following purposes:**
   ❒Change in Physician or Provider ❒To Share Treatment Plan ❒Coordinate Treatment with other providers, Bill Insurance for Payment, Allow audits and other Healthcare Operations ❒ Other_____
3. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations and that CCHD is not liable for any consequences of such disclosure.
4. I understand that I may revoke this authorization by notifying the Privacy Officer in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Cass County Health Department or other organization named in reliance on it before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand this authorization will expire on _____ (If no date entered this authorization will be good for 1 year from date of signature).

RELEASE OF HIGHLY CONFIDENTIAL INFORMATION: If you want any of the following released / disclosed, and you are 12 years of age and older, you must initial what you want disclosed; sign this section and have a witness signature.

Initials _____ mental health,

Initials _____ developmental disability,

Initials _____ alcohol and/or drug abuse, I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Initials _____ reproductive health information, genetic testing, sexually transmitted diseases including HIV/AIDS,

Initials _____ child or adult abuse and neglect,

Initials _____ sexual assault, adult disabilities,

Initials _____ sexually transmitted diseases and infectious diseases including HIV/AIDS.

☒_____ _____ ☒_____ _____

Signature of Patient 12 years and older | **Date of Signature** | **Signature of WITNESS** | **Date of Signature**

If you do **not** wish certain information to be released, **state information to be excluded**:_____

I have read and understand the terms of this Authorization and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

☒_____ _____ ☒_____ _____

Signature of Patient / Legal Guardian OR Authority to Act on Patient Behalf if not Patient | Date of Signature | PLEASE PRINT Name of Person Signing this Authorization **if not Patient** | Date of Signature