WILL COUNTY COMMUNITY HEALTH CENTER
Authorization to Release Medical Records

I HEREBY AUTHORIZE AND DIRECT: _____
Organization/Individual

_____
Street Address City State Zip Code

TO RELEASE FROM THE MEDICAL RECORD OF: _____
Patient Name Date of Birth

THE FOLLOWING INFORMATION:

[ ] *Complete* Medical Record, including but not limited to, medical reports, psychiatric reports, psychological reports, substance abuse treatment reports, educational and vocation reports, discharge summaries, consultation reports, operative reports, emergency records, physician notes and orders, nurses notes, laboratory reports, radiology reports, medication records, charts, and all records from other institutions in your possession.

[ ] Medical Record excluding: [ ] HIV/AIDS information, [ ] Alcohol/Drug abuse treatment records, [ ] Mental health treatment records, [ ] other: _____

[ ] Other (specify): _____

FROM (Date(s) of Service): _____ to _____

FOR THE PURPOSE OF: [ ] Treatment/Continuity of Care [ ] Healthcare Operations

Revocation & Re-Disclosure: I understand that I may revoke this authorization at any time by giving written notice to the person/agency listed above. If I do not revoke it, this authorization will expire in one (1) year. I understand that revocation will not effect any action taken in reliance on this authorization prior to receiving my written revocation. Once authorization has been revoked, this medical practice may not use or disclose my health information for purposes detailed in the authorization. The protected health information may be re-disclosed by the recipient.

RECORDS SHOULD BE SENT/GIVEN TO/RELEASED TO: **WILL COUNTY COMMUNITY HEALTH CTR.**
1106 NEAL AVE
JOLIET IL 60433

PERSON AUTHORIZING RELEASE OF RECORDS:

Signature of Patient: _____ Date signed: _____

Signature of Parent: _____ Date signed: _____

Signature of Guardian: _____ Date signed: _____

Witness: _____ Date signed: _____

RIGHT TO INSPECT: You have the right to inspect or copy the medical information whose disclosure you are authorizing. If you would like to inspect your records, contact the Will County Community Health Center (815) 774 – 7316 for further information.

RIGHT TO REFUSE: A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims