Authorization Form
Release of Confidential Health Information

I, _____, hereby authorize

Name: _____

Address:_____

_____

TO RELEASE TO:

Name: _____

Address:_____

_____

Litchfield Family Practice Center
1285 Franciscan Drive
Litchfield, IL 62056
www.LFPC.net

The following information contained in the patient record of: _____
(Patient's Name)

born _____, residing at _____.
(DOB) *(Street Address, City, State and Zip Code)*

The following types of information to be disclosed are as follows:

- ☐ Entire medical record, ***excluding*** highly confidential items unless checked below.
- ☐ History and Physical Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Abstract (documents summarizing history)
- ☐ Diagnostic Reports (labs, x-rays, etc)
- ☐ Other: _____

The following highly CONFIDENTIAL items **must be checked off** to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/Alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

The above information will be released for the following period of time:

From: _____ to _____.
(Date) *(Date)*

Do you want your account with this office closed? _____no _____yes

The purpose(s) of this authorization is:

_____ I have moved to a different area and will need my records transferred to a new physician.

_____ I am seeing a specialist and my records will be needed for the doctor to review.

_____ My insurance plan does not cover services provided by Litchfield Family Practice.

_____ My insurance company has requested information to:

_____ process a claim

_____ complete my application for new insurance

_____ I need to present medical information for:

_____ school enrollment

_____ job requirements

_____ I am dissatisfied with:_____

_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.

I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize [insert practice or physician name] to use or disclose my health information in the manner described above.

Patient, legal guardian, or authorized agent: _____
Signature

_____
Printed

Date: _____

Relationship to patient: _____

Witness: _____

1285 Franciscan • Litchfield, Il 62056 • Phone: 217-324-6127 • Fax: 217-324-5959