Family Care Associates of Effingham, S.C.
1106 North Merchant, P.O. Box 665 Effingham, IL 62401
Phone 217-342-7000 Fax 217-342-7002

Authorization for Release of Confidential Health Information

Patient name:_____ Telephone:_____
Address:_____
City/State/Zip:_____ Date of birth:_____

I hereby authorize: Person/Institution/Other:_____
Address:_____
City/State/Zip:_____
Phone number:_____

To release protected health information regarding the above-named person to be exchanged

TO: Family Care Associates of Effingham, S.C.

I authorize the release of information pertaining to the following time periods:
From date(s):_____ To date(s):_____

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

- □ History and physical examination
- □ Consultation reports
- □ Progress notes
- □ Operative reports
- □ Diagnostic reports (labs, x-rays, etc.)
- □ Physician discharge
- □ Emergency department record
- □ Social history
- □ Pathology reports
- □ Developmental disability records
- □ Alcohol/substance abuse
- □ HIV/AIDS
- □ Rehab Records
- □ Psychiatric outpatient notes (pre/post hospitalization)
- □ Psychiatric Evaluation
- □ Behavior Plans
- □ Mental health record
- □ Other _____

Highly CONFIDENTIAL items MUST be checked off to be EXCLUDED from this disclosure:

- □ HIV/AIDS
- □ Developmental Disabilities
- □ Drug/alcohol diagnosis, treatment
- □ Genetic testing information/records
- □ Child Abuse
- □ Sexual Assault
- □ Pregnancy

The purpose(s) of this authorization is (are):_____

This authorization expires (date):_____. If not specified, this release will expire 1 year after the date of signature (date):_____.

- 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 **Family Care Associates** to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent:_____

Signature of patient or legal guardian, or authorized agent:_____
Date:_____ **Relationship to patient:**_____
Staff signature:_____ **Date:**_____