Eagle View Community Health System

☐ P.O. Box 240, Stronghurst, IL 61480 309-924-1381 (P) 309-924-1389 (F)
☐ P.O. Box 198, Oquawka, IL 61469 309-867-2202 (P) 309-867-3205 (F)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, (full name of patient) _____ DOB: _____

Phone#:_____Address:_____City:_____State:_____Zip:_____

Authorize Eagle View Community Health System to ☐ **RELEASE TO: And/Or** ☐ **OBTAIN FROM:**

_____
(Name of person or agency releasing or obtaining information)

_____, _____, _____ _____
(Street/P.O. Box) (City) (State) (Zip)

_____ _____
(Phone #, including area code) (FAX #)

The purpose of this disclosure is: ☐ at the request of the individual ☐ other: _____

The dates of patient care covered by this Authorization are: _____

Release the Following Information:

☐ Medical Progress Notes
☐ Most Recent Lab Results
☐ Medication Information
☐ History & Physical
☐ Dental Progress Notes
☐ Dental Treatment Plan
☐ Dental X-rays
☐ Other: _____
☐ Re-disclose specific information listed below
_____

I understand that this will include information relating to **(check and initial if applicable)**
☐ _____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
☐ _____ Behavioral health service/psychiatric care
☐ _____ Treatment for alcohol and/or drug abuse

This Authorization will remain in effect:

☐ From the date of this Authorization until: _____ (Not over one year).
☐ Until the Releasing Entity fulfills the request or 120 days from the date this Authorization is signed, whichever occurs earlier.

Affirmation of Release

I give the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have stated. *I understand that I may revoke this authorization at any time in writing.* Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. I have the right to inspect and to copy the information to be disclosed. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations. A copy of this signed form will be provided to the patient if requested.

Patient/Guardian
Signature: _____ Date: _____

Witness Signature* (Must be over 18): _____ Date: _____
*Witness' Signature is required for mental health or developmental disability treatment.

(***This information is requested under the assumption that no processing fees will be assessed. If a fee will be charged please call our office and ask to speak with our Medical Records Department)***

For Office Use Only:

Initials: Date:

Rev. 08/2015