

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Patient Information:**

**Request Information From:**

\_\_\_\_\_  
 Name of Patient (please print)      Date of Birth

\_\_\_\_\_  
 Street Address (please print)

\_\_\_\_\_  
 City, State (please print)      Zip Code

\_\_\_\_\_  
 Phone Number      Cell Number

\_\_\_\_\_  
 Name of Person/Facility (please print)

\_\_\_\_\_  
 Street Address (please print)

\_\_\_\_\_  
 City, State (Please print)      Zip Code

\_\_\_\_\_  
 Phone Number      Fax Number

**Please send Information To:** Horizon Healthcare, an Affiliate of Fairfield Memorial Hospital  
1021 Harding Street, Fairfield, IL 62837  
Phone: (618) 842-4617 Fax: (618) 842 – 4743

**Purpose of Disclosure:**

\_\_\_\_\_

\_\_\_\_\_

**Specified Information to be Released:**

Progress Notes      Entire Medical Record      Lab Report  
 Consultation Report      Other \_\_\_\_\_

**Dates of Service From:** \_\_\_\_\_ **to** \_\_\_\_\_. (If no end date is indicated, this release may continue to be used for the person/facility you want medical information released for future visits, if applicable, up to the expiration of the authorization.)

**By initialing below, I am releasing the following information under this authorization:**

\_\_\_\_\_ HIV/AIDS or communicable disease information  
 \_\_\_\_\_ Mental health information  
 \_\_\_\_\_ Drug/alcohol abuse treatment information  
 \_\_\_\_\_ Developmental disability treatment information

\* This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for six months from the date of signature if no date entered.

\*This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

\*I understand that once the protected health information is disclosed, that information is subject to redisclosure and may no longer be protected by federal privacy regulation.

I hereby authorize \_\_\_\_\_ to release and/or disclose the medical information as indicated above to the healthcare facility, provider, entity, or person I have indicated above. I understand this consent is voluntary. This authorization will expire in 6 months or earlier if specified above.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this Authorization is signed by a representative on behalf of the patient, please complete the following:

Representative's Name: \_\_\_\_\_  
 (Please Print) (Legal Documentation should be provided, or already on file.)

Relationship to Patient: \_\_\_\_\_