



100 E. LeFevre Road
Sterling, IL 61081
815-625-0400
Extension#:
Fax #:

AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION

Authorization is given for the use or disclosure of the named individual's health information as described below.
CGH Medical Center is authorized to make the disclosure or obtain PHI from another source.
Please refer to the CGH Medical Center Notice of Privacy Practices

PATIENT'S NAME: MRI#:

ADDRESS: BIRTH DATE:

TELEPHONE:

SPECIFIC INFORMATION TO BE DISCLOSED OR OBTAINED:

Number of Pages:

This information may be OBTAINED FROM OR DISCLOSED TO AND USED BY the following individual or organization:

NAME:

PHONE NUMBER:

ADDRESS:

FAX NUMBER:

FOR THE PURPOSE OF:

Check here if VIEW ONLY request

I understand that this health record may include information relating to BEHAVIORAL OR MENTAL HEALTH SERVICES, TREATMENT FOR DRUG/ALCOHOL ABUSE, PHYSICAL ASSAULT/ABUSE/NEGLECT, AND/OR SEXUALLY TRANSMITTED DISEASE INCLUDING AIDS/HIV.

I understand that:

- I may inspect or copy the information to be disclosed. The individual or company requesting the health information is responsible for appropriate copy charges.
I have the right to revoke this authorization at any time and must do so in writing and present to the Health Information Dept. Such revocation does not apply to information already released in response to this authorization.
Unless otherwise revoked, this authorization expires on the following date, event, or condition:
If no expiration date, event, or condition is given, this authorization expires in sixty (60) days from date of request.
Authorizing the disclosure of this health information is voluntary. My refusal to sign this authorization does not condition uses and disclosures of PHI permitted for treatment, payment, and healthcare operations.
Disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE

If signed by Legal Representative, Relationship to Patient

This request completed by: Date: