Community Health Care, Inc.

For Same Day Release: I have verified the identity of the Patient and received photo ID

Initials_____Date:_____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

☐ CHC-Moline ☐ CHC-Rock Island ☐CHC-Dental ☐CHC-River Drive
☐CHC-East Moline ☐CHC-Clinton ☐CHC-Edgerton ☐CHC-Muscatine

Patient Name _____ **Chart #** _____
Date of Birth _____

Information to be released from:

Name/Agency: _____

Address: _____

City/State/Zip _____

Phone: _____ Fax: _____

Send requested medical information to:

Name/Agency: _____

Address: _____

City/State/Zip _____

Phone: _____ Fax: _____

Information requested for Service Dates_____to _____

□Consults/Referrals	□ ER/Hospital	□ Radiology Reports
□ Progress Notes	□ Lab Results	□ Immunization Records
□ Other_____		

Please check any items that you **DO NOT** want us to send. If left unchecked records will be sent.
☐ Sexually Transmitted Disease ☐Mental Health ☐ (drug/alcohol) ☐ HIV/Aids ☐Genetic Testing ☐Infectious Disease

This information is required for:
☐ Transfer of care ☐ Personal Copy ☐ Consultation/Referral ☐ Dissatisfaction with the clinic, please specify:_____
How would you prefer to receive your records: ☐ Paper Records ☐ CD

- I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked. I understand that this release is valid for one year from the day it was signed or on_____, and I may refuse to sign this authorization or cancel this authorization at any time. If I cancel or don't sign, it will not stop me from being seen at Community Health Care. The cancellation will take effect on the day a signed copy is received by Community Health Care. I have a right to my treatment records. Copies of my records will be given to me with advanced notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that the information may be sent again and no longer protected.
  No medical records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirement (42 CFR Part 2) prohibit further disclosure without the specific written consent of the patient.

Patient Signature _____ **Date** _____

Signature of Representative _____ **Date:** _____

Witness Signature _____ **Date:** _____

Authority to represent individual: ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Authorized Representative**