Hope Clinic

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of birth:** _____

I hereby authorize:

☐ FACILITY/PROVIDER: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ HOPE CLINIC 1602 21st Street; Granite City, IL 62040 Phone: 618-451-5722 Fax: 618-451-9092

To release to:

☐ FACILITY/PROVIDER: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ HOPE CLINIC 1602 21st Street; Granite City, IL 62040 Phone: 618-451-5722 Fax: 618-451-9092

The following health information:

☐ Complete medical record
☐ History & Physical
☐ Operative/Post-Operative Notes
☐ Pathology Report
☐ Lab and/or test results
☐ Radiology results (i.e. ultrasound or x-ray)
☐ Progress Notes
☐ Discharge Summary

☐ Other: _____

From the date(s) of treatment: _____

For the purpose of:

☐ Continuity of care with a healthcare provider/organization
☐ Other: _____
☐ Legal
☐ Personal use

This Authorization is voluntary and you may refuse to sign it. You may revoke this Authorization at any time. The revocation must be in writing with your signature and will take effect when Hope Clinic receives it. You have the right to inspect and/or receive a copy of the health information listed above and receive a copy of this Authorization form. The health information disclosed through this Authorization may no longer be protected by federal health information privacy laws. The Authorization will expire automatically 120 days from the date of signature.

_____

Print Name

_____ _____

Signature *Date*