AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____Date of Birth_____
Previous Name_____ Social Security #_____
Current Address _____Telephone # _____
_____

I HEREBY AUTHORIZE AND REQUEST
(The name of facility, address, phone number, and fax number)

_____
_____
_____

TO RELEASE AND/OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:
_____ Entire Medical Record
_____Labs____ Imaging_____ Immunizations_____ Other_____

RELATING TO THE FOLLOWING TREATMENT OF TIME PERIOD:
Beginning Date _____ through _____
For the Purpose of: __Continued Care__ Legal__ Personal __Other_____

THIS INFORMATION MAY BE RELEASED TO (CHECK ONE)
_____**Gadini Delisca, MD**
☐ 900 N 2nd St., Suite 200, Rochelle, IL 61068
☐ 2670 DeKalb Avenue, Sycamore, IL 60178
P# 815-561-2774 F# 815-561-2756
_____**Harrison Swalla, PA-C**
☐ 900 N 2nd St., Suite 200, Rochelle, IL 61068
☐ 2670 DeKalb Avenue, Sycamore, IL 60178
P# 815-561-2774 F# 815-561-2756
_____**Other** (name of other facility address and phone number)
_____
_____

I fully understand that my medical record/information in connection with hospitalization/office visit treatment dates stated above may contain test results, treatment, diagnosis, and other information relative to (Check if applicable): __ Mental Health/ Behavioral Records_ HIV/AIDS Records_ Sexual Assault/Abuse Records __Substance Abuse Records___ Genetic Testing__ STD, Pregnancy, Birth Control Records I understand that if I refuse to consent to the release of the above information it will prevent the disclosure of the information. I understand that once the information is disclosed pursuant to the authorization, it may re-disclosed by the receipt and the information may not be protected be federal privacy regulations. This authorization expires ninety (90) days from the date signed. I understand that I have the right to revoke this authorization by giving written notice to us. We will not refuse to treat patient if they do not sign this release.
Family Healthcare Clinic and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient's Signature: _____ Date: _____
(Name of Patient)

Co-signature: _____ Date: _____
(Patient/ Guardian) (Relationship)

Witness Signature: _____ Date: _____