15 Apex Drive • Highland, IL 62249 • Phone: 618-651-0444 • Fax: 618-651-9225

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I _____ hereby authorize. _____
[Name of Individual] [Name of Health Care Provider]

to use and/or disclose my individually identifiable health information described below to _____ as described below. I understand that the information
[Name of Receiving Entity]

I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:

   a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

   ☐ Mental health records
   ☐ Communicable diseases (including HIV and AIDS)
   ☐ Alcohol/drug abuse treatment
   ☐ Other (please specify): _____

2. The information will be used/ disclosed for the following purpose(s):

3. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment.

4. I understand that I may revoke this authorization at any time by notifying _____ in writing, except to the extent that:

   a) action has been taken in reliance on this authorization; or

   b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

5. This authorization expires on [upon] _____ [insert applicable date or event] or one year after signature, whichever is sooner.

_____
Patient Signature Date of Birth Date Signed