

**AUTHORIZATION FOR RELEASE OF  
PROTECTED PATIENT HEALTH INFORMATION**

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Address \_\_\_\_\_  
 Daytime Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

<b>Information to be released:</b>		
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History/Physical	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Lab results	<input type="checkbox"/> Radiology reports	<input type="checkbox"/> EKGs
<input type="checkbox"/> Operative report	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Physician Notes
<input type="checkbox"/> Other _____		
<b>Treatment Dates:</b> from _____ to _____		

<b>Information to be disclosed will be used for:</b> Check the appropriate box (s) and include other info where indicated			
<input type="checkbox"/> Continuation of Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Litigation	<input type="checkbox"/> Personal
<input type="checkbox"/> Transfer of Care	<input type="checkbox"/> Other _____		

<input type="checkbox"/> <b>Release TO Horizon Healthcare</b> 213 NW 10 <sup>th</sup> Street Ste A Fairfield, IL 62837 <b>Phone: 618 842-4617 Fax: 618 842-4743</b> ATTN: _____	<input type="checkbox"/> <b>Release FROM Horizon Healthcare</b> 213 NW 10 <sup>th</sup> Street Ste A Fairfield, IL 62837 <b>Phone: 618 842-4617 Fax: 618 842-4743</b> ATTN: _____
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Name: _____
Facility: _____
Address: _____
City: _____ State: _____ Zip Code _____
Phone: _____ FAX (If known) _____

**\*\*If information is released TO Horizon Healthcare, please return a copy of this form with the materials requested\*\***

By initialing below, I am releasing the following information under this authorization:

- \_\_\_\_\_ HIV/AIDS or communicable disease information
- \_\_\_\_\_ Mental health information (ex: depression, anxiety, or any behavioral problems)
- \_\_\_\_\_ Drug/alcohol abuse treatment information
- \_\_\_\_\_ Developmental disability treatment information

- I understand that I may revoke this authorization at any time by WRITTEN REQUEST
- I understand that the revocation will not apply to information already released in response to this authorization
- A photocopy or facsimile of this authorization will be treated in the same manner as the original, and the healthcare organization may deny release of protected health information, if 1) release is not a true and accurate authorization initiated by the patient or 2) is dated prior to the treatment dates for which records are being requested.
- I understand that once information is released pursuant to this authorization, Horizon Healthcare cannot prevent the re-disclosure of the information to a third party

**I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.**

**This Authorization will expire ONE YEAR following the date of signature except in the case of continuing care.**

Patient/Parent/Legal Responsible Party	Relationship	Date
<b>Identification for pickup is required.</b>		

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 Date Received \_\_\_\_\_ Date Processed \_\_\_\_\_ Request Completed by \_\_\_\_\_