Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth: ____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to:

[ ] Logan County Department of Public Heath

[ ] I-Care

[ ] Other_____

[ ] Information is not to be released to anyone.

[ ] Copy of Immunization Records—Charge $_____

This ***Release of Information*** will remain in effect until terminated by me in writing.

The Illinois Domestic Violence Protection (HB 5121/PA 95-0912) prohibits health care providers from releasing medical records about a child to a parent when the parent has had an order of protection filed against them. Is this a current situation? [ ] Yes [ ] No [ ] Does not apply

Signed: _____Relationship_____

Date: ____/____/_____

Witness:_____ Date: ___/____/_____