



Logan County Department of Public Health

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the Logan County Department of Public Health to release clinic and/or medical records to:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Recipient/Agency/Organization Name Date

Regarding: \_\_\_\_\_ Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Client's Address Male  
Female

For Purposes Of:

- Treatment/Screening
- Copy of Immunization Records Charge \$\_\_\_\_\_
- Other: \_\_\_\_\_ Faxed Copy?\_\_\_\_ Fax#\_\_\_\_\_

➔ 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

I agree to release the Logan County Department of Public Health, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice to the Logan County Department of Public Health. Unless I revoke my consent sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be as valid as the original even though such copy does not contain the original writing of my signature.

I hereby affirm that I am the person that I represent myself to be and that I stand in the relationship to the client as I have indicated.

\_\_\_\_\_  
Signature  Client  Guardian  Custodial/Birth Parent  Court Order \_\_\_\_\_ Date

\_\_\_\_\_  
Witness \_\_\_\_\_ Date