CRHPC AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the disclosure of my protected health information ☐ to ☐ from Christopher Greater Area Rural Health Planning Corporation (designate location). Records can also be emailed encrypted to/from him@crhpc.org (Subject line: Designate location)

___Albion CHC, 33 West Main, Albion, IL 62806	618-445-2287	Fax 618-445-2257
___Benton Mental Health Wellness Center, 107 East Smith Street, Ste B, Benton, IL 62812	618-435-9315	Fax 618-435-9316
___Carrier Mills CHC, 7211 US 45 S, Ste C, Carrier Mills, IL 62917	618-294-8246	Fax 618-294-8247
___Clay Medical Center, 165 Kinnaman Drive, Flora, IL 62839	618-662-8386	Fax 618-662-4338
___CRHPC Carmi Health Center, 103 Commerce Street, Carmi, IL 62821	618-384-5686	Fax 618-382-2882
___CRHPC Comprehensive BH Ctr, 119 GasPlant Rd, DuQuoin, IL 62832	618-790-2146	Fax 618-790-2147
___Eldorado Rural Health, 1401 US 45 North, Eldorado, IL 62930	618-273-2951	Fax 618-273-2726
___Fairfield CHC, 1007 W. Main Street, Fairfield, IL 62837	618-842-4470	Fax 618-842-3437
___Johnston City CHC, 14410 Route 37, Johnston City, IL 62951	618-983-6911	Fax 618-983-6913
___Mt. Vernon CHC, 2920 Veteran's Memorial Drive, Mt. Vernon, IL 62864	618-244-6544	Fax 618-244-6577
___Mt. Vernon Health & Wellness, 4117 S. Water Tower Pl, Ste D, Mt. Vernon, IL 62864	618-242-4848	Fax 618-242-4198
___Rea Clinic/Christopher, 4241 State Hwy 14 W, Christopher, IL 62822	618-724-2401	Fax 618-724-9257
___Rea Clinic/Benton, 206 E. Church Street, Suite B, Benton, IL 62812	618-435-9888	Fax 618-435-9889
___Rea Clinic/DuQuoin, 1564 South Washington Street, DuQuoin, IL 62832	618-542-8702	Fax 618-542-8792
___Rea Dental Clinic, PO Box 155, Christopher, IL 62822	618-724-9290	Fax 618-724-1093
___Sesser CHC, 6294 State Hwy 154, Sesser, IL 62884	618-625-6979	Fax 618-625-6549
___Shawneetown Health Care, 9525 Gold Hill Rd, Shawneetown, IL 62984	618-269-3815	Fax 618-269-3274

Information to be disclosed ☐ to ☐ from (complete name, address, phone/fax number of entity releasing/receiving information)

_____

_____

Information to be disclosed; must meet the minimum necessary standard and/or specificity:

Time Frame: Select One

___Most recent/current
___1 year
___2 years
___3 years
___Specific date _____
___Date Range_____to _____
___Other_____

Additional: _____

Requested Information:

___Office Notes
___Pap
___Colonoscopy
___Mammogram
___X-ray/CT/MRI/US-Reports only
___Lab _____
___Immunizations
___Other_____

Purpose of Release:

___Transfer Care (New PCP)
___Continued/Referral Care
___Legal
___Insurance/WC
___Personal
___Other_____
___Exchange of Information (Oral)
___Exchange of Information (Records)

***NOTE:** The following protected health information: ___Behavioral Health ___Communicable Disease, including HIV/AIDS ___Genetic Information ___ Substance Abuse (requires SUD Consent Form) ___ Reproductive Health (confirm not for investigative purposes) **WILL NOT** be released unless **specified** and signed by the patient

(release of behavioral health records may require consent of the treating provider or a court order)

Patient Signature:_____ (Age 12 and above)

This authorization shall be in force and effective for one (1) year after date signed at which time the authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the HIM Director/ Privacy Officer at Christopher Greater Area Rural Health Planning Corporation, PO Box 155, 4241 State Highway 14 West, Christopher, IL. 62822. I understand that a revocation is not effective to the extent that CRHPC has relied on the use or disclosure of the PHI. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, with the exception of specific confidential PHI, that would require a court order or patient's written consent. I understand that I have the right to inspect and copy the information disclosed. CRHPC will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand I have the right to refuse to sign this authorization. 42 CFR Part 2 records will be released per a separate authorization.

Patient Name:_____ Phone:_____

Address:_____

Date of Birth:_____ Date:_____

_____ _____

Signature of Patient/Authorized Representative CRHPC Staff Witness

*If authorization is not signed by patient, indicate his or her authority/relationship _____

FOR OFFICE STAFF USE ONLY

This authorization was completed by:

☐ Christopher Greater Area Rural Health Planning Corporation Staff ☐ Copy Service

Name _____ Date _____

This authorization was NOT completed due to:

☐ Denied Reason: _____
☐ Information was not created by Christopher Greater Area Rural Health Planning Corporation.
☐ Requested information was not available/not found.
☐ Authorization is void/invalid Reason: _____
☐ Information falls under one of the eight information blocking exceptions:
_____

Patient name _____ DOB/Acct# _____

STAFF: For tracking purposes relating to patient satisfaction, please check the box as to why the patient is transferring records.

☐ Relocating ☐ Second opinion ☐ Provider left facility ☐ Personal copies only ☐ Dissatisfied with services

Explain _____

FEES FOR MEDICAL RECORD COPIES

(Set forth by the Code of Civil Procedure 735 ILCS 5/8-2001 (d) and (h) Effective Feb. 2026)

PROCESSING FEE: $36.68 (Not applicable to patient) If less than 5 pages; copies are free of charge

Pages 01-25	**$1.38 Per Page**
Pages 26-50	**$0.92 Per Page**
Pages 51 and more	**$0.46 Per Page**
Records Released in Electronic Format	**50% of Paper Rate for the Number of Pages**
Records Retrieved from Scanning/Digital	**50% of Paper Rate for the Number of Pages**
Patient Access	**Flat Rate of $6.50**
Postage &/or Shipping	**Actual Cost of Postage &/or Shipping (USPS)**

*******INVOICE (FOR OFFICE USE ONLY)*******

	Number of Pages	Charge per Page	Total
Processing Fee @ $36.68			
Number of Pages @ $1.38		$1.38	
Number of Pages @ $0.92		$0.92	
Number of Pages @ $0.46		$0.46	
Number of Pages Released in Electronic Format (50% of cost of paper rate)			
Number of Pages Retrieved from Scanning/Digital (50% of cost of paper rate)			
Patient Access (Flat Fee)		$6.50	
Postage &/or Shipping			
TOTAL CHARGES			

Revisions: 10/20/10, 04/02/12, 08/28/14, 09/22/15, 04/26/16, 05/17/16, 08/23/16, 02/27/17, 01/25/18, 05/15/19, 08/2019, 10/2019, 12/2020, 05/02/2022 , 02/15/2023, 11/05/2024, 01/30/2025, 06/30/2025, 12/22/2025, 02/02/2026