AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my protected health information ☐ to ☐ from
Christopher Greater Area Rural Health Planning Corporation (designate location)

Location	Phone	Fax
___Albion CHC, 33 West Main, Albion, IL 62806	(618) 445-2287	Fax (618) 445-2257
___Clay Medical Center, 201 E. North Ave, Flora, IL 62839	(618) 662-8386	Fax (618) 662-4338
___CRHPC Carmi Health Ct, 103 Commerce Street, Carmi, IL 62821	(618) 384-5686	Fax (618) 382-2882
___Eldorado Rural Health, 1401 US 45 North, Eldorado, IL 62930	(618) 273-2951	Fax (618) 273-2726
___Fairfield CHC, 209 NW 11th 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 Mem Drive, Mt. Vernon, IL 62864	(618) 244-6544	Fax (618) 244-6577
___Rea Clinic, PO Box 155, Christopher, IL 62822	(618) 724-2401	Fax (618) 724-9257
___Rea Clinic/Duquoin, 119 Gas Plant Road, Duquoin, IL 62832	(618) 542-8702	Fax (618) 542-8792
___Rea Clinic/Herrin, 3303 Logan Drive, Herrin, IL 62948	(618) 993-5767	Fax (618) 993-4005
___Rea Dental Clinic, PO Box 155, Christopher, IL 62822	(618) 724-9290	Fax (618) 724-4628
___Sesser CHC, 6294 State Hwy 154, Sesser, IL 62884	(618) 625-6979	Fax (618) 625-6549
___Sesser Dental Clinic, 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 and address of entity releasing/receiving information)

____

____

Information to be disclosed (must meet minimum necessary standard and/or specificity):

	Dates		Purpose of release:
Entire chart	Dates: From__________	To__________	__Transfer/Change Care
Progress notes	Dates: From__________	To__________	__Continue/Referral Care
X-ray reports and/or films	Dates: From__________	To__________	__Legal
Labs	Dates: From__________	To__________	__Insurance/WC
Other __________	Dates: From__________	To__________	__Other__________

***NOTE:** The following protected health information; ___HIV/AIDS ___Mental Health records ___Substance Abuse ___Communicable Disease ___Genetic Information **WILL NOT** be released unless specified and signed by patient below:

Patient Signature:____

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 such written notification to the Health Information Manager/ 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 Christopher Greater Area Rural Health Planning Corporation has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure (***except those noted above**) by the recipient may no longer be protected by federal or state law. Christopher Greater Area Rural Health Planning Corporation 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 that I have the right to refuse to sign this authorization.

Patient Name:____ Phone:____________________

Address:____

Date of Birth:______________________________

______________________________________ ______________________________

Signature of Patient/Authorized Representative Date

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

FOR OFFICE STAFF USE ONLY

This authorization was witnessed by:____

This authorization was completed by:

☐ Christopher Greater Area Rural Health Planning Corporation Staff

______________________________ ______________________________
Name Date

☐ 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:____
☐ Other:
____

Amount charged & paid (follow 735 ILCS 5/8): $________________.

Patient name______________________________ DOB/Acct#____________________________________

Facility name ________________________________

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____

____

____

10/20/10
04/02/12
08/28/14
09/22/15
04/26/16
05/17/16
Policy Form 2012-08F