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)

☐ Albion CHC, 33 West Main, Albion, IL 62806	(618) 445-2287	Fax (618) 445-2257
☐ 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
☐ 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 Memorial 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, 1564 South Washington Street, Duquoin, IL 62832	(618) 542-8702	Fax (618) 542-8792
☐ Rea Clinic/Benton, 206 E. Church Street, Suite B, Benton, IL 62812	(618) 435-9888	Fax (618) 435-9889
☐ 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
☐ 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, address, phone/fax number of entity releasing/receiving information)

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_____

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

Time Frame:

- ☐ Most recent/current
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ Specific date _____
- ☐ Date Range _____ to _____
- ☐ Other_____

Requested Information:

- ☐ Office Notes
- ☐ Pap
- ☐ Colonoscopy
- ☐ Mammogram
- ☐ X-ray/CT/MRI/US
- ☐ Lab _____
- ☐ Other_____

Purpose of Release:

- ☐ Transfer Care
- ☐ Continue/Referral Care
- ☐ Legal
- ☐ Insurance/WC
- ☐ Personal
- ☐ Other_____

Additional:_____

***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

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

Patient Name:_____

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 (***except those noted above**) by the recipient may no longer be protected by federal or state law. 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. The information authorized for release may include drug and/or alcohol treatment records and are protected under Federal confidentiality rules (42 CFR Part 2) and Federal rules prohibit anyone receiving this information from further release unless it is expressly permitted by the written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

Patient Name:_____ Phone:_____

Address:_____

Date of Birth:_____ Date:_____

_____ _____

Name of Patient/Authorized Representative CRHPC Staff Witness

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