Midwest Medical Center and Midwest Health Clinic
Authorization to Release Information

Patient Name (Printed):_____ Date of Birth:_____

I authorize:_____ _____
Name Street Address

_____ _____ _____
City State Zip Code Phone FAX #

To disclose the information described below to: MIDWEST MEDICAL CENTER / MIDWEST HEALTH CLINIC, One Medical Center Drive, Galena, IL 61036

Please specify the information to be released:
☐ Hospital Records ☐ Clinic Records
☐ All medical records, including lab, x-ray, immunizations, and records and correspondence obtained from other healthcare providers.
The following categories are ***EXCLUDED*** from disclosure, unless specifically checked: ☐ Mental health information (including ADHD);
☐ AIDS/HIV-related information, diagnosis, test results; ☐ Substance abuse (drug or alcohol).

☐ **OTHER**:_____

The requested disclosure of information is for the following purpose: _____

This authorization expires one year from the date signed. I understand that I may revoke this authorization at any time by a written request to do so. Midwest Medical Center/Midwest Health Clinic does not require completion of this form as a condition of evaluation or treatment.

The undersigned patient (guardian or legal representative, if applicable) hereby recognizes that the medical information and medical records sought to be disclosed are privileged and confidential, and subject to disclosure upon the authorization of the undersigned only, except where provided by law. The undersigned patient may review the disclosed information by contacting the Midwest Medical Center/Midwest Health Clinic, One Medical Center Drive, Galena, IL 61036; Telephone (815)777-1340 (hospital) or (815)776-7381(clinic). I further understand that recipients of this information may possibly re-release the information without proper authorization, and that once information is disclosed, it may no longer be protected by federal privacy regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

X_____ _____
Signature of patient (or patient's legal representative) Date

Printed name of patient's legal representative:_____ _____
(Parent, Guardian, Healthcare POA, etc.) Relationship (if not the Patient)

The following must also be completed if the information to be disclosed is protected by the Illinois Mental Health and Developmental Disabilities Confidentiality Act, or the Federal Confidentiality of Alcohol and Drug Abuse Patient Records Act.

The specific nature of the information to be disclosed is:_____

The purpose of the disclosure is:_____

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any):

_____

I understand that the person or entity receiving this information has the right to inspect and copy the information to be disclosed:

Signed X_____ Date:_____

Witness:_____ _____ Date:_____
Signature Printed Name

NOTICE TO RECEIVING AGENCY/PERSON: *Release of Mental Health Information* (including ADHD): Under provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. *Release of Substance Abuse Information*: Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no information from such records herein authorized for release may be further disclosed without specific consent to such re-disclosure. *Release of AIDS/HIV Related Information*: Under Federal Privacy rules, AIDS/HIV related information may not be re-disclosed unless the person who consented to this disclosure specifically authorizes such re-disclosure.

(For internal use) Date copied:_____; (circle) mailed/faxed/personal pickup; initial_____