DeWitt-Piatt
Bi-County Health Department

PREVENT • PROMOTE • PROTECT

www.dewittpiatthealth.com

AUTHORIZATION FORM TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I, ____ hereby authorize DeWitt-Piatt Bi-County Health Department to:
(Name of client or personal representative)

_______DISCLOSE _______OBTAIN _______DISCLOSE AND OBTAIN (please initial choice)

Information Concerning:

____ ______________________
(Name) *(Date of birth)*

To/From: ____
(Name of person/provider to disclose/obtain information)

______________________________________ ______________________________________
(Phone Number) *(Fax Number)*

____
(Address)

____
(Email Address)

The information should include (mark all applicable):

- _____ Laboratory Reports (i.e., pregnancy test, lead) Specify ______________________________
- _____ Immunization Records
- _____ Anthropometrics (i.e., weight, height, blood pressure, head circumference)
- _____ Prenatal Visit Dates/Information
- _____ Developmental Screening Results
- _____ EPSDT Dates (Well Child Exams)
- _____ Dental Records
- _____ Contact Information
- _____ Other Health Care Records Specify____

____

The purpose of this authorization is:

_____ to comply with the request of the individual or their designated personal representative, which may include parents, legal guardians, spouses, grandparents or other authorized parties.
_____ other: ____

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Piatt County Office • 1020 S. Market St., • Monticello, IL 61856 • Ph. 217.762.7911 • Fax 217.762.3422

I request the records be disclosed/obtained (mark all applicable):

_______ Printed copy to be picked up

_______ Mailed

_______ Emailed

_______ Faxed

I understand this authorization does not grant permission for the release of any records concerning mental health treatment, alcohol or other drug treatment, HIV/AIDS status or test results, and/or genetic information.

I understand that I have the right to revoke this authorization by giving written notice to the DeWitt-Piatt Bi-County Health Department (DPBHD). I understand that if the DPBHD has already used or released my health information in reliance to this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by the law.

I understand that DPBHD must allow or deny the right of access to records within 30 calendar days of receiving a written request. I understand that I have a right to ask to review my records at any time and to ask for an amendment to my records. I understand that DPBHD can deny a request for amendment of my records but must do so in writing.

I understand that the DPBHD may not condition treatment, payment, enrollment or eligibility for benefits based on my signing this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected. I understand that this authorization is valid for 3 years from today's date or until I revoke it in writing by delivering a written revocation to DPBCHD. I am entitled to a copy of this authorization upon request.

SIGNATURE: ____ DATE: _______________

PHONE NUMBER: ____

If you are the personal representative of the client, please specify your relationship to the client: _______________

____

OFFICE USE ONLY:

Signature of employee disclosing/obtaining records: ______________________ Date of release: _____________

Signature of employee disclosing/obtaining records: ______________________ Date of release: _____________

Signature of employee disclosing/obtaining records: ______________________ Date of release: _____________

Rev. 2/03, 5/11, 9/16, 3/23, 8/24