HEARTLAND HEALTH CENTERS
HEALTHCARE FROM THE HEART

REQUEST FOR INFORMATION TO HHC

Patient Name : _____ MRN: _____
Last First M.I.

Date of Birth: _____/_____/_____ Phone #: _____
Month Day Year

I authorize Heartland Health Centers to release medical records (which may be copied, orally communicated, or faxed) from my record as stated below:

Information to be released FROM:	Information to be released TO:
_____ Organization/Person Name _____ Street Address _____ City, State, Zip _____ Phone & Fax Numbers	**[HEARTLAND HEALTH CENTER SITE]:**

Sensitive Information (Initial below if you do NOT want the following info to be disclosed):

_____ HIV/AIDS _____ Mental Health _____ Alcohol/Substance Use ____ Genetic Testing

For the following dates of treatment: _____ to _____ (if blank, we will release records from the past 12 months)

Type of information (entire record will be released unless specified): _____

Purpose of Disclosure: □ Transfer of care to another provider □ Referral/Consultation □ Disability determination
□ Insurance claim □ Personal use □ Other: _____

This authorization is valid until _____/_____/_____ (Date not to exceed 1 year)

I acknowledge that I have fully reviewed and understand the contents of this form. I acknowledge that a photocopy or fax of this form is valid. I understand that I have the right to inspect and receive a copy of the information to be disclosed. I understand that I may refuse to consent to the release of the above information and that I may revoke this authorization at any time except to the extent action has already been taken. I understand that my consent is voluntary; however, my refusal may hamper further evaluation or treatment. I understand that if the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. However, Illinois law does not allow the re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR. I understand that if the patient is 12-17 years old, the patient and a witness must sign this consent in order to disclose certain protected information, pursuant to the Consent by Minors to Medical Procedures Act and the Mental Health and Developmental Disabilities Confidentiality Act. Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Signature of Minor if Patient is 12-17 years old Date

_____ _____
If not Patient, then Name and Relationship to Patient (for example, parent) Date

_____ _____
Witness/Signature of Heartland Health Centers Staff Member (Required) Date