HORIZON HEALTH

Phone No. 217-465-4141 / 217-465-8411
Fax No. 217-465-5615 / 217-463-3184

Authorization to Release Information

Patient Name: _____ **Social Security No.:** _____

Address: _____ **Date of Birth:** _____

I authorize _____ to release my patient information to:

_____ _____
Name of facility / person(s) Address (Street, City, State, and ZIP code)

_____ _____
Phone No. (Include Area Code) Fax No. (Include Area Code)

Period of Treatment: _____ - _____ ☐ All past, present, and future records

Reason for request / use of medical information: (X if applicable)

☐ Personal use ☐ Continued Medical Care ☐ Legal
☐ Insurance ☐ School ☐ Other (specify) _____

Information to be released:

☐ All records ☐ Alcohol abuse care ☐ Mental health care
☐ Imaging ☐ Drug abuse care ☐ AIDS / HIV care
☐ Insurance/Billing ☐ All records (except alcohol or drug abuse, mental health or AIDS/HIV care)

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided in my regulations. I also understand that I may revoke this consent at any time, except to the extent of those actions that have already been taken.

This information has been disclosed to you from records protected by Federal Confidentiality Rule (42 CRF, Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information to criminally investigate or prosecute any alcohol or drug abused patient.

_____ _____
Signature of patient, parent, or legal representative Date

_____ _____
Signature of witness Date

Records prepared by: _____

Date request satisfied: _____