



**AUTHORIZATION FOR RELEASE OF INFORMATION**

175 S. Main St.  
Canton, IL 61520  
(309) 647-0201  
(309) 649-6880 Fax

114 S. 4<sup>th</sup> St.  
Cuba, IL 61427  
(309) 785-5156  
(309) 649-6880 Fax

141 E. Vernon St.  
Farmington, IL 61531  
(309) 245-2406  
(309) 649-6880 Fax

2001 N. Main St.  
Lewistown, IL 61542  
(309) 547-9700  
(309) 649-6880 Fax

Patient/Guardian needs to fill out:

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

RECORD MAY BE UNDER ANOTHER NAME: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

I authorize: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

To release to: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

(Check one):  Full Medical Record  Last five years of Medical Record  
 Partial Record (Specify dates and information needed) \_\_\_\_\_  
\_\_\_\_\_  
 Original x-ray films with copy of report\*

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SPECIAL AUTHORIZATION FOR RELEASE OF SENSITIVE INFORMATION:**

*I authorize release of sensitive information, including presence of a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS) and/or any mental health records, or any substance abuse records. (Pursuant to the Mental Health and Developmental Disabilities Act\*\* of the Alcoholism and Substance Abuse Act\*\*\*)*

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\*With my signature, I assume responsibility to return original x-rays within 14 days  
\*\*625 ILCS 35/1  
\*\*\*20 ILCS 305/8-102

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OFFICE USE ONLY: ACCT# \_\_\_\_\_ CHART# \_\_\_\_\_

DATE REQUEST SENT \_\_\_\_\_ SENT BY \_\_\_\_\_

DATE X-RAYS RETURNED \_\_\_\_\_ REC'D BY \_\_\_\_\_