Williamson County Office:
8160 Express Drive
Marion, IL 62959-9808
Phone 618/993-8111
Fax 618/993-6455

www.bicountyhealth.org

Franklin County Office:
403 East Park
Benton, IL 62812-1920
Phone 618/439-0951
Fax 618/438-3005

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

I give permission to send/or pick up my health information from Franklin- Williamson Bi-County Health Department to the following:

Person(s)/ to **Release** Information to:		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Franklin-Williamson Bi-County Health Department has permission to send my health care information to the following person/organization:

Person/Organization to <u>Receive</u> Information:		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from ____________________ to ____________________, may be released:

- **Entire Medical Record**

I further understand that my medical record may include one or more of the following:

- **All medical records pertaining to TB skin test regulations, TB infection and TB disease.**

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for **24 months** following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority: