

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_

Maiden/Previous name(s): \_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I.

The undersigned hereby authorizes the release of information

To / From John Deere Medical Group of the Quad Cities, P.C.
4101 John Deere Road , Moline, Illinois 61265
Ph: (309) 765-1600 Fax: (309) 765-1610



To / From: \_\_\_\_\_

Please include phone number \_\_\_\_\_

if available. \_\_\_\_\_

Information to be released:

- \_\_\_\_\_ All
\_\_\_\_\_ Immunizations / Growth Charts
\_\_\_\_\_ Labs
\_\_\_\_\_ X-Rays
\_\_\_\_\_ Other \_\_\_\_\_

CHECK ONE:

- \_\_\_\_\_ Copy my entire record
(I understand there will be a charge
or this)
\_\_\_\_\_ Please provide a summary
of my records (no charge)

I realize this includes limited information

II.

Specific Authorization for Release of Information Protected by State or Federal Law
Indicate YES or NO for each

- \_\_\_\_\_ Substance Abuse Information
\_\_\_\_\_ Mental Health Information
\_\_\_\_\_ AIDS/HIV – Related Information, Diagnosis and/or Test Results

III.

The information is to be disclosed for the purpose of \_\_\_\_\_

I Specifically Authorize disclosure of this confidential information to all of the persons referred to in Section I. In order for the above information to be released, you MUST sign on both lines below.

Signature of Patient, Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

I understand that I have the right to inspect the disclosed information at any time. This authorization is effective for 12 months after the date signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. A photocopy or an exact reproduction of this signed Authorization shall have the same force or effect as the original. I understand the information is being disclosed and may be used only for medical, legal, and/or litigation purposes.

Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying costs. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and will no longer be protected by the regulations.

Signature of Patient, Parent or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

Office Use Only
Information was: Given to Patient Mailed Faxed Other
Completed by: patient\_auth\_ml.doc
Date: \_\_\_\_\_