

Instructions for filling out the form you need  
Incoming Medical records:

- Patient Name
- Name of Facility you are requesting the medical records to be sent.
- Address of facility you are requesting medical records to be sent. If no address is entered we may not be able to retrieve your request
- Date information is to be disclosed from and thru.
- Check Mark all the information to be disclosed.  
If you check other please give brief description.
- Date of Medical authorization will be in effect (30 days).
- Date of Birth and Social Security Number is required.
- If you are not the patient requesting medical information, signature of authorized personal is required.
- Printed name, signature, and photo ID is required, but must be witnessed by a Logan Primary Care Employee.
- If at any time any of this information is not completed, your request may be rejected. Please ask questions if needed.

**Authorization for Disclosure of Protected Health Information**

I \_\_\_\_\_ authorize \_\_\_\_\_  
Print Patient's Name Name of Facility  
located at \_\_\_\_\_ to disclose the following protected health  
address City State Zip  
information on myself or \_\_\_\_\_ which may include the diagnosis and treatment of Mental Health, Drug and  
Alcohol abuse and/or HIV or other Sexual Transmitted diseases to:

**Logan Primary Care Phone: 618-993-3300**  
**405 Rushing Drive Fax: 618-998-9826**  
**Herrin, IL 62948**

The information to be disclosed is from \_\_\_\_\_ thru \_\_\_\_\_  
(Date) (Date)

Please place a check mark next to the type of health information to be disclose:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chart Summary                   | <input type="checkbox"/> Nurses Notes              | <input type="checkbox"/> Medications/RX     |
| <input type="checkbox"/> Progress Notes                  | <input type="checkbox"/> Injections, Immunizations | <input type="checkbox"/> Vital Signs        |
| <input type="checkbox"/> Past, Social, or Family History | <input type="checkbox"/> Flow Chart                | <input type="checkbox"/> Lab Data/Pathology |
| <input type="checkbox"/> Problem List                    | <input type="checkbox"/> Images                    | <input type="checkbox"/> EKG                |
| <input type="checkbox"/> Letters                         | <input type="checkbox"/> Health Maintenance        | <input type="checkbox"/> Complete Chart     |
| <input type="checkbox"/> Patient Forms                   | <input type="checkbox"/> X-ray Reports             | <input type="checkbox"/> Other              |

If you checked "other": Please give a brief description : \_\_\_\_\_

This protected health information is being used or disclosed for the following purposes:  
("At the request of the individual"-is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose)

This authorization shall be in force and effect from \_\_\_\_\_ thru \_\_\_\_\_  
(Authorization is good for 30 days). (Date) (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Logan Primary Care at 405 Rushing Drive, Herrin, IL 62948. I understand that a revocation is not effective to the extent that my physician has relied on the disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient's D.O.B.

\_\_\_\_\_  
Patient's SS #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Witness Signature \*\*Not valid without a witness signature\*\*

\_\_\_\_\_  
Description of Personal Representative's Authority