

Instructions for filling out the form you need
Outgoing 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 honor 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.

**Logan Primary Care
405 Rushing Drive
Herrin, IL 62948**
Authorization for Disclosure of Protected Health Information

I _____ authorize Logan Primary Care to disclose the following protected health information
Print Patient's Name

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:

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:

_____ Chart Summary	_____ Nurses Notes	_____ Medications/RX
_____ Progress Notes	_____ Injections, Immunizations	_____ Vital Signs
_____ Past, Social, or Family History	_____ Flow Chart	_____ Lab Data/Pathology
_____ Problem List	_____ Images	_____ EKG
_____ Letters	_____ Health Maintenance	_____ Complete Chart
_____ Patient Forms	_____ X-ray Reports	_____ 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