



**AUTHORIZATION FOR THE RELEASE OF INFORMATION
SECTION A**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by the federal privacy regulations. **PLEASE FILL OUT ENTIRE FORM.**

Patient Name: _____ Birth Date: _____

Daytime phone number: _____

Organization or Doctor providing the information: _____

Address of organization or Doctor providing information: _____

Phone number of organization or Doctor: (_____) _____

Name and address of persons/organization receiving the information:

**Progressive Family Care Ltd
509 Hamacher Street Suite 103
Waterloo, IL 62298
Phone: (618) 939-2273**

Provider you will be transferring to at PFC: _____

Specific description of information (including dates): _____

Purpose for which information is being requested: _____

SECTION B

1. I permit the release of all information concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases, test results and/or diagnosis and treatment.
2. I understand that this authorization will expire one year from the date listed below.
3. I understand that I may be required to pay the cost of preparing and mailing copies except for uses and disclosures for the purposes of treatment, payment and operations. I understand that this may be charged to me and payment in full must be made before information is released.

Signature patient/Patient's representative _____ Date _____

Basis of representative's authority to act for patient _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION