GRAHAM FAMILY MEDICINE

4501 W. DeYoung Street, Suite 107B
Marion, IL 62959
Ph: (618) 998-9200 Fax: (618) 998-9700

I hereby authorize the use or disclosure of my protected health information (PHI) as described below:

_____ _____ _____
Name D.O.B. S.S. #

Persons or organizations providing information: Persons or organization receiving information:

_____ _____
_____ _____
_____ _____
_____ _____

Information to be disclosed:

___Office Visits
___Emergency Room Reports
___Discharge Summary
___Operative Reports
___History & Physical
___Cardiac Reports
___Laboratory Reports
___Radiology Reports
___Physical/Occupational Therapy Reports
___Homecare Records
___Radiation Oncology Records
___Other_____

I authorize the release of information about alcohol/substance abuse, HIV/AIDS and/or Mental Health. Yes or No (circle one)

Purpose of the Intended Information:_____
(e.g., *continuing care, personal use, legal, financial, etc).*

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release ***Graham Family Medicine*** from any and all liability which may arise as a result of my authorized release of records.

My information may be disclosed/obtained by Mail, In-Person, Phone, E-Mail or by Fax.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, it will be returned and result in my information not being released until completed.

_____ _____/_____/_____
Signature of Patient/Patient's Personal Representative *Date Signed*

_____ _____
*** Printed Name* *Relationship, if not Patient*