



Logan County Department of Public Health

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Logan County Department of Public Health to release clinic and/or medical records to:

_____/_____/_____
Parent/Recipient/Agency/Organization Name Date

Regarding: _____ Date of Birth_____/_____/_____
Client's Name

Client's Address Male
Female

For Purposes Of:

- Treatment/Screening
- Copy of Immunization Records Charge \$_____
- Other: _____ Faxed Copy?____ Fax#_____

➔ The Illinois Domestic Violence Protection (HB 5121/PA 95-0912)-Prohibits health care providers from releasing medical records about a child to a parent, when the parent has had an order of protection filed against them.

Is this a current situation? YES NO Does Not Apply

I agree to release the Logan County Department of Public Health, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice to the Logan County Department of Public Health. Unless I revoke my consent sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be as valid as the original even though such copy does not contain the original writing of my signature.

I hereby affirm that I am the person that I represent myself to be and that I stand in the relationship to the client as I have indicated.

Signature Client Guardian _____ Date
 Custodial/Birth Parent
 Court Order

Witness _____ Date