

**LIVINGSTON COUNTY HEALTH DEPARTMENT**  
**P.O. BOX 650, 310 E. TORRANCE**  
**PONTIAC, IL 61764**  
**PHONE: 815-844-7174 Fax: 815-844-7468**

**AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ hereby authorize Livingston County Health Department  
(Name of Patient or Personal Representative)  
to release the information listed below to:

\_\_\_\_\_  
(Name of Person to Receive Information)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

from the designated record set of \_\_\_\_\_ whose birth date is \_\_\_\_\_  
(Patient's Name)

and whose address is \_\_\_\_\_.

The following information shall be released (mark all applicable):

- Entire Medical Record, Except for Records Concerning Mental Health Treatment Alcohol, or Other Drug Treatment, HIV/AIDS Information, and Genetic Information.
- Mental Health Treatment Records
- Alcohol or Other Drug Treatment Records
- HIV/AIDS Records
- Genetic Information
- Laboratory Reports
- X-Ray or Other Photographic Reports
- Immunization Records
- Other: \_\_\_\_\_.

The purpose of the authorization is:

- At the Request of the Individual or Personal Representative
- Other: \_\_\_\_\_.

The information should be released for the following time period: from \_\_\_\_\_ to \_\_\_\_\_  
(Start Date) (End Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provide by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on \_\_\_\_\_.  
(Date)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are the personal representative of the patient, please specify your relationship to the patient: \_\_\_\_\_