CARBONDALE
All Ways Open

CITY OF CARBONDALE POLICE DEPARTMENT
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Case #:_____

I, _____, hereby authorize _____
(Person Signing Authorization) (Healthcare Provider)

to furnish the following information to an agent of the City of Carbondale Police Department, 501 S. Washington Street, Carbondale, Illinois 62901 and/or the Jackson County Illinois State's Attorney, 1001 Walnut Street, Murphysboro, Illinois 62966.

Purpose of Disclosure: ☐ Request of Individual ☐ Other_____

Patient Name	Date of Birth

Specific Information to be Released: Date of Treatment:_____

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Emergency Room Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Other _____
- ☐ Itemized Bill

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department of the Southern Illinois Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition this authorization will expire in 6 months, or (Date)

I understand that the information (excluding mental health information) that is being disclosed under this authorization, may be subject to re-disclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree that a photocopy of this authorization is as valid as the original.

Signed:_____ Date:_____
(Patient/Legal Representative

If signed by other than the patient, please indicate relationship and why patient did not sign:_____

_____

Witness: _____ Date:_____
(Officer Name & ID #)