RURAL HEALTH, Inc.
We specialize in you

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I hereby authorize the disclosure of my protected health information (please circle one) **TO** or **FROM**

Rural Health, Inc. (designate a location below)

☐	Anna Medical Clinic, 513 N. Main St., Anna, IL 62906	P (618) 833-4471 F (618) 833-6267
☐	Dongola Medical Clinic, 318 US Highway 51 N, Dongola, IL 62926 PO Box 277, Dongola, IL 62926	P (618) 827-3545 F (618) 827-4891
☐	Goreville Medical Clinic, 211 N. Broadway, Goreville, IL62939	P (618) 995-1002 F (618) 995-1133
☐	Metropolis Medical Clinic, 1003 E. 5th St., Metropolis, IL62960	P (618) 524-7499 F (618) 833-6267
☐	Vienna Medical Clinic, 803 N. 1st St., Vienna, IL 62995	P (618) 658-2811 F (618) 658-2439

Information to be disclosed ☐ to ☐ from
(complete name, address, phone number, and fax number of entity releasing/receiving information)

_____

_____

Information to be disclosed (must meet minimum necessary standard and/or specify)

		Purpose of Release
Entire Chart	Dates: From _____	___ Continue/Referral Care
Encounter Notes	Dates: From _____ To _____	___ Legal
X-Ray Reports	Dates: From _____ To _____	___ Insurance/Work Comp
Labs	Dates: From _____ To _____	___ Transfer/Change Care & Reason
Other: _____	Dates: From _____ To _____	**Reason:** _____

***NOTE: The following protected health information WILL NOT be released unless specified and initialed by patient below:**

_____ *HIV/AIDS _____ *Mental Health Records _____*Substance Abuse _____DENTAL

*** 42 CFR Part 2 prohibits unauthorized disclosure of these records**

I understand that the above-mentioned named receiving agency/person/facility has a right to inspect and copy the information disclosed. I further understand that if the receiving agency/person/facility is not covered by Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, the information described above may be re-disclosed and may no longer be protected by HIPAA regulations. I understand that I may revoke the release of information at any time, in writing, except where the facility has already made disclosures in reliance upon my prior authorization. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by Rural Health, Inc. It is my understanding that the records and communication to be disclosed may contain information about diagnoses/evaluation/rehabilitation/treatment/recommendation for mental health, developmental disabilities, and/or substance abuse/use and that my signature indicates my informed consent. All authorizations will expire 365 days from the date signed unless otherwise noted below.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Name:_____ Phone: _____

Mailing Address: _____ City:_____ State: _____

Date of Birth: _____ Today's Date: _____

_____ _____

Signature of Patient/Authorized Representative RHI Staff Witness