700 EAST OAK STREET
CANTON ILLINOIS 61520
Phone: 309-647-1134
Fax: 309-647-9545
Contact Us On The Web At:
www.fultoncountyhealth.com

Astoria Sub-office
309-329-2922

Cuba Sub-Office
309-785-5300

FULTON COUNTY HEALTH DEPARTMENT

An Equal Opportunity Employer and Provider

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________________ hereby authorize the Fulton County Health Department
(Name of Patient or Personal Representative)

to **release** or **obtain** 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** or **obtained** (mark all applicable):

- ☐ Pap Reports of ______________________
- ☐ STD Reports of ______________________
- ☐ Other: ______________________
- ☒ Other: I give permission for the above named person to pick up my birth control supplies.

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: ______________________.

FCHD: 4/03