AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PACT for West Central IL, Central Office 2090 HWY 24, Camp Point, IL 62320 (217-773-3903, fax # 217-773-3906)

I, the parent/guardian of named child, hereby authorize named health provider to release the specific health information marked to PACT for West Central Illinois for the purpose of maintenance of health records and planning and assisting with any follow up treatment needed.

Child Name _____ DOB ___/___/___ CB/Area #___
Parent/Guardian name _____
Street Address _____
City, State, Zip _____

Information to be released from:

Health Provider _____
Street Address _____
City, State, Zip _____
Phone # _____ Fax # _____

Release the following information marked☒. A form is attached to use if needed.

- ☐ **Most recent physical exam (using IDPH Health Exam form)**
- ☐ **Most recent well baby check - Systems Review & Dictation (age _____mo.)**
- ☐ **Most recent well baby check - (using IDPH Health Exam form) (age _____mo.)**
- ☐ **12mo blood lead level test results ☐ 24mo blood lead level test results**
- ☐ **TB test results or physician sign off of not indicated**
- ☐ **Immunization record**
- ☐ **Hematocrit or hemoglobin results**
- ☐ **Dental exam/treatment**
- ☐ **Hearing screening**
- ☐ **Vision screening**
- ☐ **Other: _____**

I understand that I may revoke this authorization by giving written notice. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the provider in reliance before I revoked it. I understand that the information used or disclosed may be subject to re-disclosure by the agency receiving it and is no longer protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization requests it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits from the provider releasing information (listed above). I understand that this authorization is valid one year from the date signed, or until I revoke it in writing to the agency releasing information.

_____ _____
(Parent or DCFS Authorized Agent Signature) (Date)

Send requested information to:

PACT for West Central Illinois
2090 HWY 24
Camp Point, Illinois 62320
FAX # 217-773-3906