CB/Area # _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH (V/H) INFORMATION

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

☐ **Hearing/ENT Report**
☐ **Vision**

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

Information to be released from:

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

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/Guardian or DCFS Authorized Agent Signature) (Date)

FA or HBT mail to provider

****

Physician, please complete and sign the information below and return this form to: PACT for West Central Illinois, 2090 HWY 24, Camp Point, Illinois 62320. Phone 217-773-3903 Fax 217-773-3906

Date last seen in your office _____ **Results** _____
_____

Date of latest Hearing test _____ **Results** _____
_____

Is further treatment needed? ☐ Yes ☐ No If yes, date due for return visit _____
State progress of condition and list any things PACT could do to assist: _____
_____
_____

Signature _____ **date** _____

Mail or fax to: PACT for West Central Illinois, 2090 HWY 24, Camp Point, Illinois 62320.
Phone 217-773-3903 Fax 217-773-3906 H- 2/22