109 Third Street, P.O. Box 508
Lincoln, IL 62656-0508
www.lcdph.org

Public Health
Prevent · Promote · Protect

Phone: 217-735-2317
Fax: 217-735-1872
Email: info@lcdph.org

Logan County Department of Public Health

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Logan County Department of Public Health to release clinic and/or medical records to:

_____ _____/_____/_____
Parent/Recipient/Agency/Organization Name Date

Regarding:

_____ Date of Birth_____/_____/_____
Client's Name

☐ Male

_____
Client's Address ☐ Female

For Purposes Of:

☐ Treatment/Screening

☐ Copy of Immunization Records Charge $_____

☐ Other:_____ Faxed Copy?____ Fax#_____

- The Illinois Domestic Violence Protection (HB 5121/PA 95-0912)-Prohibits health care providers from releasing medical records about a child to a parent, when the parent has had an order of protection filed against them.

Is this a current situation? ☐ YES ☐ NO ☐ Does Not Apply

I agree to release the Logan County Department of Public Health, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice to the Logan County Department of Public Health. Unless I revoke my consent sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photostatic copy or facsimile of this consent will be as valid as the original even though such copy does not contain the original writing of my signature.

I hereby affirm that I am the person that I represent myself to be and that I stand in the relationship to the client as I have indicated.

_____ ☐ Client _____
Signature ☐ Custodial/Birth Parent Date
☐ Guardian
☐ Court Order

_____ _____
Witness Date