Crusader Community Health
1200 West State Street
Rockford, IL 61102
Phone: 815-490-1600 Fax: 815-490-1881

Crusader Community Health Authorization for Disclosure of Protected Health Information

Patient Name:		Account Number:	
Maiden Name:	Date of Birth:	Phone Number:	
Street Address:	City:	State:	Zip:

I hereby authorize:

Crusader Community Health 1200 West State Street Rockford, IL 61102	Disclose to:	Name: RECORDS DEPOSITION SERVICE Street Address: P.O. BOX 5054 City, State, Zip: SOUTHFIELD, MI 48086-5054

[✓] Written [ ] Verbal

Name: Street Address: City, State, Zip:	Disclose to:	Crusader Community Health 1200 West State Street Rockford, IL 61102

[ ] Written [ ] Verbal

Description of information that may be disclosed. Please check all that apply. Dates from ________ to ________

- [ ] History and Physical Exams
- [ ] X-rays
- [ ] Substance Abuse
- [ ] HIV/AID or AIDS related complex
- [ ] Development disabilities
- [ ] Mental Health
- [ ] Medical Photographs
- [ ] Other: ____________________
- [ ] Progress Notes
- [ ] Immunizations
- [ ] Laboratory and EKG Reports
- [ ] Communicable diseases or infections (including STD's, TB and hepatitis)
- [ ] Genetic Testing

Information will be used/disclosed for the following reasons:

- [ ] Transfer of Primary Care Provider
- [ ] Personal

If transferring care, please check reason below:

- [ ] Primary Care
- [ ] Service Dissatisfaction
- [ ] Convenience
- [ ] Moving
- [ ] Specialist Referral
- [ ] Coverage Limitation
- [ ] Other: Completion of Records

- I may refuse to sign this authorization. Crusader Community Health may not condition my treatment on my provision of this authorization.
- I have the right to revoke this authorization at any time, except where information has already been released in reliance on my authorization. Revocation requests must be made in writing, except for a revocation request related to substance abuse treatment information which may be given verbally. Revocation requests should be made to the Privacy Officer.
- I understand that a reasonable fee may be charged for duplication of records. A photocopy or fax of this authorization is as valid as the original.
- Crusader Community Health, its directors, officers, employees, agents, and volunteers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Crusader.
- I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal confidentiality laws; however, the recipient my be prohibited from re-disclosing information pertaining to substance abuse.

Signature of Patient or Responsible Party and Relationship to Patient:	Date:
Witness and Signature Verified:	Date:
This Authorization will expire on: ____________________	

Release sent out:	To be picked up:	Records sent:	Initials: