LEWIS & CLARK COMMUNITY COLLEGE
DISCOVER

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Family Health Clinic • FO 1525 – 5800 Godfrey Rd., Godfrey, IL 62035
Telephone: 618-468-6800 Fax: 618-468-7410

Patient Name (Please Print)			
Name (If different) at time of visit(s) or treatment(s)			
Date of Birth:		**S.S.# Last 4 digits:**	**Telephone:**

Release Information To:			**Date (s) of Visit (s):**
Name:			
Email:	**Phone #:**		
Address:			
City:			
State:	**Zip**		
Delivery: **Times listed below are estimates only.** ❑ **Mail USPS: 3 to 10 Business Days** ❑ **Encrypted Email: 3 to 5 Business Days** ❑ **Onsite pick up on this date:**			
Additional Comments:			

Information to be released:

❑ Entire Record ❑ Lab Results ❑ Visit Records ❑ Radiology Records

❑ Other (Specify) _____

AUTHORIZATION

I the undersigned, hereby authorize the release of the above personal health information as I have indicated.

I understand that there may be a charge per page depending on the purpose of this request. I understand that I may revoke this authorization to release information at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

_____ _____

Patient/Guardian Signature Date

PLEASE NOTE: If emailed, the information contained in the email message is privileged and confidential and intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the content of this telecopied information is strictly prohibited. If you have received this copy in error, please immediately notify the sender to arrange for return of the original documents to us.

For Office Use only:

☐ Completed by initials: _____ Date: _____