

**Medical Information Release Form  
(HIPAA Release Form)**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to:

Logan County Department of Public Health

I-Care

Other \_\_\_\_\_

Information is not to be released to anyone.

Copy of Immunization Records—Charge \$ \_\_\_\_\_

This **Release of Information** will remain in effect until terminated by me in writing.

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

Signed: \_\_\_\_\_ Relationship \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_