The Country Doctor, Ltd.
2310 CountryRoad
Shiloh, Illinois 62221-2570
(618) 277-3197

DATE _____

Dear :

The listed patient on this form has requested his/her records from your practice/hospital, consisting of the listed private health information (PHI). Please send any History and physical information, SOAP notes, pertinent labs and studies, and any other information about the listed patient to The Country Doctor, Ltd, 2310 Country Road, Shiloh, Illinois, 62221-2570. Thank you.

Sincerely,

Needs closer doctor/ All
Dates of Service

H&PS, Labs, SOAP notes
Information to be disclosed

Please check the boxes of other confidential infomation that you would like sent to The Country Doctor, Ltd.

- ☐ Information about a Mental Illness or Disability
- ☐ Psychotherapy Notes
- ☐ Information about HIV/AIDS and STDTesting or Treatment
- ☐ Information about Abuse and sexual assault
- ☐ Information about Child Abuse and Neglect
- ☐ Information about Genetic Testing

This authorization remains effective until:

- ☐ Until I revoke it in writing.
- ☐ From the date of this Authorization until the _____ day of _____ , 200
- ☐ Until the following occurs: _____

I understand that once the Practice discloses my PHI to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my PHI to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my PHI.

I understand that I may refuse to sign or may revoke at any time this Authorization for any reason and that such refusal or revocation will not affect the treatment of me, except if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to The Country Doctor, Ltd, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and had I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Patient Signauture or Representative Physician Signature or Representative

_____
Date Signed

_____ _____ _____ _____ _____
Prefix Last name Middle name First Name DOB

Phone # _____