Community Health Care, Inc.
Opening Doors to Health Care

Name of Staff Member Initialing Release _____
Same Day Release _____ ScanStat Release _____

Consent to Release Information

River Drive Clinic	Dental Clinic	Moline Clinic	Rock Island Clinic	Regional Virology Clinic
√500 West River Drive	125 Scott Street	1106 4th Avenue	2750 11th Street	1351 W. Central Park
Davenport, Iowa 52801	Davenport, Iowa 52801	Moline, IL 61265	Rock Island, IL 61201	Suite 360
563-336-3000 – Phone	563-336-3221 – Phone	563-327-2000 – Phone	563-327-2100 – Phone	Davenport, Iowa 52804
563-336-3125 – Fax	563-336-3229 – Fax	563-327-2045 – Fax	563-327-2102 – Fax	563-421-4244 – Phone
				563-421-4285- Fax

Patient Name _____ Chart # _____
Date of Birth _____

Information to be released from:

Name/Agency: River Drive Clinic
Address: 500 West River Dr.
City/State/Zip Davenport IA 52801
Phone: 563-336-3000 Fax: 563-336-3125

Send requested medical information to:

Name/Agency: Black Hawk Area Special Ed. Dist
Address: 4670-11th Street
City/State/Zip East Moline, Il 61244
Phone: 309-796-2500 Fax: 309-796-2911

CHECK INFORMATION NEEDED:

☐ Immunizations ☒ Progress Reports ☐ Lab Reports ☐ Radiology Reports/X-ray ☐ Consult/Referrals

☐ ER/Hospital ☐ Other Diagnosis, medications, and restrictions

Please check any items that you **DO NOT** want to be released. If left unchecked, CHC will release this information.

☐ STD's ☐ Mental Health ☐ Substance abuse (drug/alcohol) ☐ HIV/Aids ☐ Genetic testing ☐ Infectious disease

This information is required for:

☐ Transfer of care ☐ Personal Copy ☒ Consultation/Referral ☐ Dissatisfaction with the clinic, please specify: _____

XEligibility for DHS-DRS services

I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked. I understand that this release is valid for 60 days and I may refuse to sign this authorization or revoke this authorization at any time. If I revoke or refuse to sign, it will not affect my ability to obtain treatment or my eligibility for benefits. The revocation will take effect on the day a signed copy is received by Community Health Care. I have the right to access my treatment records. Copies of my records may be obtained with reasonable notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that my privacy may no longer be protected.

Patient Signature _____ **Date** _____

Signature of Representative _____ **Date:** _____

Authority to represent individual: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

For Same Day Release: I have verified the identity of the patient and obtained a photo ID of the person to whom the authorized release is to be made.

Staff Signature _____ Date _____

02-02/09-09