Covenant Clinic
Wheaton Franciscan Healthcare

Patient Request for Release of Clinic Information

This Authorization grants permission to the Designated Party(ies) named below to: make or confirm appointments; have access to X-ray, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up sample medications; be made aware of my diagnosis, prognosis, and treatment plans; and/or have access to my financial health information in order to assist with the management of my care. The patient or the patient's representative must check the appropriate box:
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☐ Health-Care Related ☐ Financial / Billing Related

I hereby authorize Wheaton Franciscan Healthcare Covenant Clinic to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient's Name: ______________________ **DOB** __________ **SSN:** ________________

Designated party: ____

Relationship to patient: ____

Address: ______________________________ Phone # ______________

Designated party: ____

Relationship to patient: ____

Address: ______________________________ Phone # ______________

The patient, or the patient's representative, must read and initial the following statement:

1. I understand that this authorization will be effective for the lifetime of the patient unless revoked (see #2 below) .... Initials: _____
2. I understand that I may revoke this authorization at any time by notifying Wheaton Franciscan Healthcare in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Wheaton Franciscan Healthcare prior to their receipt of the revocation. .... Initials: _____
3. I understand that my treatment cannot be conditioned on whether I sign this authorization. .... Initials: _____

Signature of patient or patient's representative ______________________________

Date ____________ **Printed name of patient/representative** ______________________

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