

**Family Care Associates of Effingham, S.C.**

1106 North Merchant, P.O. Box 665 Effingham, IL 62401

217-342-7000

**PERMISSION TO RELEASE MEDICAL RECORDS**

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

PERMISSION IS HEREBY GRANTED FOR RELEASE OF ALL MEDICAL INFORMATION

FROM: \_\_\_\_\_

\_\_\_\_\_

TO: \_\_\_\_\_

\_\_\_\_\_

INITIAL

\_\_\_\_\_ I consent to release of all medical information.

\_\_\_\_\_ I do specifically consent to transmission of my medical records via a facsimile (fax) machine.

\_\_\_\_\_ I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law. I specifically consent to disclosure of such information.

\_\_\_\_\_ I recognize that the information disclosed may contain mental health information including depression that is protected by federal and state law. I specifically consent to disclosure of such information.

\_\_\_\_\_ I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV/AIDS testing information. I specifically consent to disclosure of such information.

This permission expires 3 months from the date of \_\_\_\_\_.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_