Dr. Naveed Sadiq / Dr. Irfan Sadiq
735 N. Logan Ave.
Danville, IL 61832
Phone (217) 443-9100
Fax (217) 443-6792

DANVILLE POLYCLINIC LTD.
707 N. Logan Ave.
Danville, IL 61832-4360
Phone (217) 446-6410
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Covington Polyclinic
416 Union St.
Covington, IN 47932
Phone (765) 793-2122
Fax (765) 793-1104

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____ Clinic # _____
Other Name (s): _____ Social Security # _____
Street Address: _____ City, State and Zip: _____
Telephone (Home): _____ Telephone (Work): _____

I authorize Danville Polyclinic, Ltd., to use or disclose my individually identified health information as described below.

Specific information authorized to be used or disclosed (including dates of healthcare):

_____

_____

Organization(s) or Person(s) Danville Polyclinic, Ltd., is authorized to release my information from:

_____

_____

Organization(s) or Person(s) Danville Polyclinic, Ltd., is authorized to release my information to:

_____

_____

Purpose(s) of the use or disclosure:

☐ At the request of the patient
☐ Other

_____

_____

_____

I understand the following:

Any information used or disclosed because I have signed the authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving it.

I have a right to revoke this authorization at any time by doing so in writing and presenting my written revocation to the Medical Records Department of Danville Polyclinic, LTD.

Any request to revoke my authorization will not apply to the extent Danville Polyclinic, Ltd., has taken action in reliance upon my authorization. Any request to revoke this authorization will not apply to my insurance company when the law provides my insurer with the right to contest acclaim under my policy or the policy itself.

I may refuse to sign this authorization and you will not condition treatment based upon my providing a signature on this authorization unless it is for research-related treatment or the provision of care for the sole purpose of creating information for a third party. If I refuse to sign in either of these two instances, I understand that you may refuse to treat me.

I may inspect or copy any information to be used or disclosed based upon this authorization.

If this authorization is for marketing purposes and you will receive compensation from a third party for use or disclosure of my information, I understand that you will inform me of this arrangement.

This authorization expires 6 months after the date of execution.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Personal Representative's Relationship to Patient Witness

707 N. Logan Ave.
Danville, IL 61832-4360
Phone (217) 446-6410

RECORD RELEASE

SPECIFIC AUTHORIZATION

FOR RELEASE OF MENTAL HEALTH INFORMATION DRUG/ALCOHOL ABUSE INFORMATION, GENETIC TESTING, AND/OR SEXUALLY TRANSMITTED DISEASE INCLUDING AIDS/HIV INFORMATION.

PatientName:_____ Date of Birth: _____

Street Address: _____

City, State and Zip: _____

Telephone (Home): _____ Telephone (Cell): _____

I acknowledge that date to be released may include material that is protected by Federal Law 42 CFR Part 2, which is applicable to mental health, drug/alcohol abuse information, genetic testing, and/or sexually transmitted disease information. My signature authorizes release of all such information (as specified above)

Please release the records from: _____

_____

_____

Please release the records to: _____

_____

_____

_____ _____

Parent Signature (parent or guardian if minor) Date