1250 E US HWY 36
Tuscola, IL 61953

DoCo Health Center

P: 217.253.4137
F: 217.558.9548

Authorization for Release of Medical and/or Behavioral Health Records

I, (printed patient/client or parent/guardian name) _____, (birthdate) _____, hereby authorize the provider and staff of the Douglas County Health Center (DCHC) to release records or knowledge concerning my medical or behavioral health to:

Practice/Provider Name:_____

Street Address:_____

City, State, Zip Code:_____

Practice/Provider Phone Number:_____ **Practice/Provider Fax Number:** _____

I specifically request DCHC release copies of:

- ☐ All laboratory testing results
- ☐ All medical notes
- ☐ All behavioral notes
- ☐ All behavioral assessments

Patient/Client or Parent/Guardian Signature: _____ Date:_____

Authorization to Disclose/Obtain Medical and/or Behavioral Health Records

I, (printed patient/client or parent/guardian name) _____, (birthdate) _____, hereby authorize the below listed practice/provider to release records or knowledge concerning my medical or behavioral health to the Douglas County Health Center (Fax: 217-558-9548):

Practice/Provider Name:_____

Street Address:_____

City, State, Zip Code:_____

Practice/Provider Phone number:_____ **Practice/Provider Fax Number:** _____

I specifically request DCHCproviders and staff request copies of:

- ☐ All laboratory testing results
- ☐ All medical notes
- ☐ All behavioral notes
- ☐ All behavioral assessments

Patient/Client or Parent/Guardian Signature:_____ Date:_____

Patient/Client or Parent/Guardian Printed Name:_____ Date:_____

Witness Printed Name:_____ Date:_____