



Shannon Graves, APN

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I understand:

- ❖ That I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- ❖ That the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- ❖ That information used or disclosed pursuant to this authorization may subject to redisclosure by the recipient and may no longer be protected by law.
- ❖ That this authorization is valid until it expires, unless revoked before the date provided.
- ❖ That I may revoke this authorization at any time by giving a dated written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. A dated written revocation must be sent to the physician's office.
- ❖ That I have read and understand the terms of the authorization and I have had the opportunity to ask questions about the use and disclosure(s) of my health information.
- ❖ There is a copy fee of \$25.

By signing below, I knowingly and voluntarily authorize the disclosure of my protected health information as described above.

X _____ ____/____/_____
Printed Name of Patient, Legal Guardian, or Authorized Agent Date

X _____
Signature of Patient, Legal Guardian, or Authorized Agent

Relationship to Patient

X _____
Witness Signature