SOUTHERN ILLINOIS PHYSICIANS GROUP

Consent to Release Information

I hereby consent to the use or disclosure, by Southern Illinois Physicians Group, Ltd., of my individually identifiable health information/protected health information described below ("Health Information"). I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

☐ I consent to the disclosure and use of the Health Information described above to the following person(s) or organization(s) as noted below: *(Please list any family members, guardians, friends or legal counsel with whom we are allowed to discuss your treatment or billing issues. Dependents over age 18 must give consent for release of information; they may indicate "Unrestricted" and name one or both parents. But the fact that they are over 18 does require us to "protect" their health information and does require consent for release of information. Information regarding dependents under 18 can only be released to either parent or legal guardian (unless there is a court order restriction), but requires parental consent for release other than as allowed by law.)*

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

☐ I **DO NOT** want my information discussed with anyone other than myself.

Comments: _____

_____

_____

Print Patient Name _____

Patient Signature _____ Date _____

Parent/Guardian Signature if under 18 _____ Relationship _____