AUTHORIZATION

TO USE AND DISCLOSE HEALTH INFORMATION

FOR PURPOSES OTHER THAN TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient's Name:____ Date of Birth:__________________________

Address:____ SSN#:__________________________________

____ Phone #:______________________________

I authorize the ☐ Warner Hospital & Health Services ☐ Other ____ to disclose the protected health information contained in my medical records as directed below:

1. The name and address of the person(s), the class of person or the organization(s) to whom disclosure is to be made and by whom use can be made of my protected health information:
   ____

2. Approximate dates of treatment: ____

   Specific description of health information to be released:

☐ Complete Medical Record ☐ History & Physical ☐ Alcohol & Drug Abuse
☐ Operative/Procedure Report ☐ Discharge Summary ☐ HIV Tests Results & Related Information
☐ Emergency Room ☐ MD Progress Notes ☐ Psychiatric (Only if this box is checked will psychiatric records be released)
☐ Face Sheet ☐ Lab, X-Ray, Pathology Reports
☐ X-ray images/CD ☐ Other____

3. The purpose for disclosing and/or using the protected health information:
   ____
   (At the request of the individual; further care; transfer of care; insurance claim; attorney inquiry, etc.)

4. Unless revoked by me sooner, this authorization shall be effective for ninety (90) days after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below.

5. I understand and acknowledge that the protected health information disclosed and/or used pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by law.

6. I understand and acknowledge that I may revoke this authorization in writing at any time by directing the written revocation to the Warner Hospital & Health Services or Medical Records Department, Clinton, Illinois. I further understand and acknowledge that my revocation may not be effective to the extent that 1) the Warner Hospital & Health Services has already taken action in reliance upon the authorization or 2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. I understand and acknowledge that the Warner Hospital & Health Services may not condition my treatment on whether I sign this authorization, except when the treatment is performed for a third party (such as an employer or insurance carrier) and the protected health information is to be disclosed directly to that third party. In that case my failure to sign this authorization may result in the denial of or other restriction on such treatment.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

____ ______________________________
Signature of Patient or Legally Authorized Representative *Date*

____
If not Patient, then Relationship of Legally Authorized Representative to Patient

ID Verified By: ☐ Driver's License #____________________________ ☐ Known to Me ☐ Other

____ ______________________________
Released by *Released*