AUTHORIZATION

Patient Authorization for Disclosure of Health Information

PLEASE PRINT

Print Name:_____ Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____Zip:_____

E-mail Address:_____ Phone:_____

I request that my protected health information (PHI) *from* _____ be disclosed to:

Recipient Name:_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address:_____ Phone:_____

Fax:_____

I authorize the following PHI to be released from my medical record(s): *Please check box*

☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Pathology Report ☐ Cardiology Report(s)

☐ Immunization Record ☐ Provider Office Visit ☐ Cornerstone Counseling ☐ Any and All Records

☐ Abstract/Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations and Test Result(s):

☐ Test Result(s) of:_____

☐ Radiology film/imaging studies/tracing/media

☐ Itemized Billing Records

☐ Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please Indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health	☐ Yes	☐ No	Dates: _____
Psychotherapy Records	☐ Yes	☐ No	Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

☐ Other (*Please specify on line below*):

_____

Disclosure Format (Paper is default if not marked):

☐ US Mail – Paper Format ☐ Fax ☐ E-mail (Secure Format with Encryption)
☐ E-Mail (Unsecure Format, i.e., Gmail, Yahoo) ☐ CD (Radiology Images Only)
☐ Flash Drive – Secure Format
☐ Other (Please Specify): _____

(**Over)**

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state guidelines.
- I have the right to revoke this Authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: *422 W. White St., Clinton, IL 61727.* Revocation will not apply to information that has already been disclosed in response to this Authorization.
- Unless otherwise revoked, this Authorization will expire on the following date/event/condition:
  _____
- If I fail to specify an expiration date/event/condition, this Authorization will expire *90 DAYS* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this Authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date and Time

_____ _____
Print Name Relationship to Patient (if applicable)

(For Office Use Only)
Account Number: _____ **Medical Record Number:** _____

ID Verified By: ☐ **Driver's License:** _____ ☐ **Known to Me** ☐ **Other**

Released By: _____

Release Date & Time :_____