SOUTHERN ILLINOIS HEALTHCARE

- ❑ Herrin Hospital
- ❑ St. Joseph Memorial Hospital
- ❑ Memorial Hospital of Carbondale
- ❑ Miners Memorial Health Center

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I,____________________________________ hereby authorize____________________________ to
(Person Signing Authorization) (Healthcare Provider)

furnish the following medical information to ____________________________________________

______________________________________________________________________
(Name and Address of Receiving Party)

Purpose of disclosure: ❑ Request of individual ❑ Healthcare treatment / services ❑ Other ________________

Patient Name: ____________________________________________ Date of Birth:________________

Specific Information to be Released: Date of Treatment: ____________

- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Emergency Room Report
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Other____________________
- ❑ EKG / Stress Test
- ❑ Radiology Films / Images
- ❑ Itemized Bills

Request Format: ❑ Paper ❑ DVD

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months, or ________________.
(date)

I understand that the information (excluding mental health information) that is being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree that a photocopy of this authorization is as valid as the original.

Signed: ________________________________________________ Date:______________
(Patient / Legal Representative)

If signed by other than the patient, please indicate relationship and why patient did not sign: ____________________

______________________________________________________________________

Witness:________________________________________________ Date:______________
(Hospital Employee)