Holy Family Medical Center

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

INSTRUCTIONS: This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

SECTION 1 - Patient Information

Patient Full Name - First, Middle, Last:			Birthdate: Month _____ Day _____ Year _____
Patient Address - Street/Apt/Suite:	City:	State:	Zip:
Phone Number:	Fax Number:	**Social Security Number** (Last 4) **XXX-XX-** _ _ _ _	**OFFICE USE ONLY:** Patient MRN/Encounter Number

SECTION 2 - Disclosure of Health Information

I authorize_____ **to** ☐ **Disclose** ☐ **Obtain** ☐ **Disclose and Obtain**
(facility name)

Disclose To

Name of Facility/Entity/Individual:			
Street Address/Apt/Suite:	City:	State:	Zip:
Phone Number:	Fax Number:		

Obtain From

Name of Facility/Entity/Individual:			
Street Address/Apt/Suite:	City:	State:	Zip:
Phone Number:	**For Direct Patient Care Only** - Fax Number:		

SECTION 3 - Purpose Of Disclosure

☐ Legal ☐ School ☐ Further Care/Treatment ☐ Transfer/Placement
☐ Insurance ☐ Personal Use ☐ Other (specify) _____

SECTION 4 – Requested Format

☐ Paper ☐ Electronic Media ☐ Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 5 - Delivery Method

☐ Mail ☐ Pick-Up ☐ Secure Email (email address) _____ ☐ Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 6 - Dates of Treatment

Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017): _____

SECTION 7 - Medical/Surgical Health Information To Be Disclosed - Check All That Apply

☐ Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests).

☐ Emergency Report
☐ History and Physical(s)
☐ Consultation(s)
☐ Progress Note(s)
☐ Operative/Procedure Report(s)
☐ Laboratory Results
☐ Pathology Results
☐ Radiology Report(s)
☐ Radiology films/digital images
☐ EKG/Stress Test(s)
☐ Clinic Notes (specify clinic) _____
☐ Rehab or Therapy Notes (specify type) _____
☐ Prenatal Summary _____
☐ Entire Chart
☐ Itemized Bill
☐ Other (specify) _____
☐ Discharge Summary

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PATIENT ID

SECTION 8 – Specific Consent MUST BE COMPLETED FOR ALL REQUESTS

If any of the highly confidential information listed below is contained in the medical records requested, I am specifically authorizing the use and/or disclosure of this information by checking the boxes below, if applicable to this authorization.

- ☐ Information about Mental/Behavioral Care and Treatment
- ☐ Information about Substance Abuse Care and Treatment
- ☐ Information about Psychological Testing
- ☐ Information about HIV/AIDS Testing or Treatment
- ☐ Pregnancy (the patient 12 or over must authorize this release)
- ☐ Information about Sexually Transmitted Disease(s)
- ☐ Information about Genetic Testing
- ☐ Information about Sexual Assault/Abuse
- ☐ Information about Child Abuse and Neglect
- ☐ Not Applicable to this authorization

SECTION 9 – Behavior Health/Substance Use Disorder Treatment Information To Be Disclosed

Behavioral/Substance Abuse Health Information To Be Disclosed – Check All That Apply

☐ Inpatient Stay: An abstract of the record will be provided, which includes Test Results, History and Physical, Psychiatric Evaluation, Consultations, Discharge Summary, Face Sheet, unless otherwise specified._____

- ☐ History & Physical Screen
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Psychological Evaluation
- ☐ Treatment Plan
- ☐ Itemized Bill/Insurance
- ☐ Dates of Admission and Discharge
- ☐ Progress Notes
- ☐ Medication information
- ☐ Laboratory Results
- ☐ Radiology Results
- ☐ Assessment (specify type) _____
- ☐ Behavioral/History of Client

Education Department

- ☐ Psychiatric Diagnosis
- ☐ Medical Diagnosis
- ☐ Treatment Information
- ☐ Homework Information
- ☐ Attendance/Tuition
- ☐ CD Diagnosis
- ☐ Follow Up Care
- ☐ IEP of 504 Plan

☐ Other (specify) _____

SECTION 10 – Authorization Expiration Date

This authorization is approved for: ☐ This occurrence only ☐ 60 days from the date of signature

☐ 1 year from the date of signature (mental health records only) *Only effective for this occurrence if none is chosen.

SECTION 11 – Important Information

I have read and understand the following statements:

Note: If the authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the date the request is received. If this authorization is for medical/surgical or research, an expiration date is not required.

I understand that my health information may be shared with other Ascension Illinois healthcare providers for the purposes of treatment and care coordination.

I understand that I have the right of access to inspect and obtain a copy of my health Information.

I understand that I can cancel this authorization at any time by submitting a written notice to the physician office or **Health Information Management Department of the hospital where my health information is stored.** I understand that my cancellation will take effect when the Health Information Management Department receives my written notice.

I understand that my cancellation will not have any effect on health information released before the Health Information Department received my written notice.

I understand that health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

I understand that under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that failure to provide all required information on this authorization form will not constitute a proper authorization to disclose protected health information, including the refusal to sign this authorization and that, therefore, my request may not be honored.

I understand that refusal to sign this authorization will not affect any conditions of my treatment, payment, enrollment, or eligibility for benefits.

SECTION 12 – Signatures

***Patients 12-17 years of age** must sign for Behavioral Health, Substance Abuse, HIV/AIDS, STD, Pregnancy, Birth Control information.

****Legal Representative or Guardian,** please attach a court order or other documentation designating your legal status, as applicable.

*****Signature of witness** who can attest to the identity of the authorized signatory is required to release any mental health or developmental disability information. The witness cannot be the same person as the authorized signatory.

_____ ____/____/_____ _____ ____/____/_____

*Signature of Patient Date *** Signature of Witness Date

_____ ____/____/_____ _____

**Signature of Parent, Legal Representative or Legal Guardian Date Relationship of Parent, Legal Representative or Legal Guardian

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