AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

MUST COMPLETE ALL BLANK LINES

PATIENT INFORMATION	Patient Name:____________________________________ Address:___________________________ City, State, Zip Code:____ Phone Number: _(______)_____________________ Date of Birth: ______________
PROVIDER/ORGANIZATION: (Who is authorized to release your information)	**I hereby authorize:** OSF Healthcare OSF Hope Center, 617 NE Glendale, Peoria, Illinois 61603
REQUESTOR: (To whom you want your information to go)	**To Release my medical records to:** Name: _____________________________________ Address: ___________________________City, State, Zip Code:____________________________ Phone Number: _(______)_______________
PURPOSE	☐ Continuing Care ☐ Insurance ☐Legal ☐ Personal ☐Other ___________________________ ☐ Encrypted Email ____________________________
INFORMATION TO BE DISCLOSED:	☐ Abstract ☐ Entire Medical Record ☐Lab Results ☐ Radiology Results☐Imaging Films ☐Medical Bills ☐Other(please be specific):____ Date(s) of Visit: ____

<u>HIGHLY CONFIDENTIAL INFORMATION</u>

It is my full understanding that the records and communications to be disclosed <u>WILL</u> include Highly confidential information such as HIV/AIDS, drug and alcohol abuse, sexually transmitted disease, genetic testing, mental health information, and reproductive health information. If you want to have any of this information excluded, check below.

☐ **Alcohol/Substance Abuse** ☐ **Mental Health** ☐**Developmental Disabilities** ☐**HIV/AID's** ☐**Genetic Testing**
☐ **Reproductive Health (*Attestation must accompany Authorization*)** ☐ **Other:** __________________

<u>SUBSTANCE ABUSE INFORMATION</u>

I ☐ do ☐ do not want **substance abuse** information released under this authorization.

- *Substance Abuse information is protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for the purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient*

Both pages need to be completed to be valid

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By signing below,

- I have reviewed all information on page one and filled it out completely.
- I understand that this authorization is voluntary and I can refuse to sign this authorization. I understand that person(s) or organization(s) may NOT condition my treatment, payment or enrollment based on my signature on this authorization.
- I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and once the information is re-disclosed it **may not be protected** by the HIPAA privacy rule.
- I understand I have **the right to revoke** this authorization at any time. If I revoke this authorization I must do so in writing to the Health Information Department of the OSF Healthcare Facility listed above under Provider/Organization. I understand that the revocation will not apply to information that has already been disclosed in response to this release.
- I understand I have the right to inspect the information to be disclosed.
- I understand this authorization will **expire 1 year from the date of the signature** below or **upon a date, event or condition that I am specifying here:** ______________________________

______________________________ ______________

Signature of Patient *Date*

______________________________ ______________

Signature of Child (12-17) for MHDDCA purposes only *Date*

405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act

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Signed by Patient Representative, state relationship to Patient and provide evidence of Authority to act for individual

______________________________ ______________________ ______________

Signature of witness who can verify patient identity *Relationship to Patient* *Date*

(Must be signed for Substance Abuse information to be released)

Both pages need to be completed to be valid