PRINT

OSF HEALTHCARE

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*MUST COMPLETE ALL BLANK LINES*

| | |
|---|---|
| **PATIENT INFORMATION** | Patient Name:_____<br>Address:_____<br>City, State, Zip Code:_____<br>Phone Number: _(_____)_____ Date of Birth: _____ |
| **PROVIDER/ORGANIZATION:**<br>(Who is authorized to release your information) | **I hereby authorize:**<br>Name: _____<br>Address: _____City, State, Zip Code:_____<br>Phone Number: _(____)_____ |
| **REQUESTOR:**<br>(To whom you want your information to go) | **To Release my medical records to:**<br>Name: OSF Saint Katharine Pediatrics<br>Address: 144 North Court City, State, Zip Code: Dixon, IL 61021<br>Phone Number: _( 815 )285-5437 Fax Number: 815-285-8928 |
| **Disclose Records to** | ☐ OSF MyChart ☐ CD (mailed to address above) ☐ Paper (mailed to address above)<br>☐ Encrypted Email _____ Fax: 815-285-8928 |
| **PURPOSE** | ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other _____ |
| **INFORMATION TO BE DISCLOSED:** | ☐ Abstract ☐ Entire Medical Record ☐ Lab Results ☐ Radiology Results ☐ Imaging Films ☐ Medical Bills<br>☐ Other (please be specific): _____<br>Date(s) of Visit: _____ |

***HIGHLY CONFIDENTIAL INFORMATION***

***It is my full understanding that the records and communications to be disclosed WILL 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/AIDS** ☐ **Genetic Testing**
☐ **Reproductive Health** ☐ **Other:** _____

**By signing below**,

- 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 or Patient Representative*** ***Date***

_____ _____
***Signature of Child (12-17) for MHDDCA purposes only*** ***Date***
***405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act***

_____
***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*** ***Date***