OSF HEALTHCARE

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 Alton - Saint Anthony's Health Center, #1 Saint Anthony's Way, Alton, IL 62002
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 _____
INFORMATION TO BE DISCLOSED:	☐ Abstract ☐ Entire Medical Record ☐Lab Results ☐ Radiology Results ☐Other(please be specific):_____ Date(s) of Visit: _____

HIGHLY CONFIDENTIAL INFORMATION

I ☐ do ☐ do not want HIV/AIDS information released under this authorization.

I ☐ do ☐ do not want genetic testing information released under this authorization.

I ☐ do ☐ do not want sexually transmitted disease information released under this authorization.

I ☐ do ☐ do not want mental health information released under this authorization. If age 12-17 must be signed by the child below.

_____

SUBSTANCE ABUSE INFORMATION

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*

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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

_____
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)