OSF HealthCare

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*MUST COMPLETE ALL BLANK LINES*

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|---|---|
| **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>☐ Dixon - Saint Katharine Medical Center - 403 E. First Street, Dixon, Illinois 61021 |
| **REQUESTOR:**<br>(To whom you want your information to go) | **To Release my medical records to:**<br>Name: _____<br>Address: _____City, State, Zip Code:_____<br>Phone Number: _(_____)_____ Fax Number: _____ |
| **Disclose Records to** | ☐ OSF MyChart ☐ CD (mailed to address above) ☐Paper (mailed to address above)<br>☐ Encrypted Email _____☐ Fax_____ |
| **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 all Highly confidential information such as alcohol and substance abuse, mental health, developmental disabilities, HIV/AIDS, and genetic testing and information derived from genetic testing information.***

***If you want to have any of this information excluded, check below.***

☐ **Alcohol/Substance Abuse** ☐ **Mental Health** ☐**Developmental Disabilities** ☐**HIV/AIDS** ☐**Genetic Testing and information derived from genetic testing** ☐ **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 and copy 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, print name. state relationship to patient and provide evidence of Authority to act for individual***