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*** Dixon - Saint Katharine Medical Center - 403 E. First Street, Dixon, Illinois 61021
REQUESTOR: (To whom you want your information to go)	**To Release my medical records to:** Name: ______________________________________ Address: ____________________________City, State, Zip Code:_____________________________ Phone Number: _(______)_______________ Fax Number: ______________________
Disclose Records to	☐ OSF MyChart ☐ CD (mailed to address above) ☐Paper (mailed to address above) ☐ Encrypted Email _____________________________
PURPOSE	☐ Continuing Care ☐ Insurance ☐Legal ☐ Personal ☐Other ____________________________
INFORMATION TO BE DISCLOSED:	☐ Abstract ☐ Entire Medical Record ☐Lab Results ☐ Radiology Results☐Imaging Films ☐Medical Bills ☐Other (please be specific): ____ 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

____
If 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***