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 signatur**e below or **upon a dat**e, **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)

Both pages need to be completed to be valid