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:** (Select One)
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:
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 drug/alcohol abuse or treatment 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.

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 ***Date***

_____ _____

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

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Signed by Patient Representative, state relationship to Patient and provide evidence of Authority to act for individual

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Signature of witness who can verify patient identity