



# HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

### To release the personal health information of:

Patient's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

To release to: Recipient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

To release from: Releasing Entity: \_\_\_\_\_ Phone #: \_\_\_\_\_

The purpose of this disclosure is:  At the request of the individual  Other: \_\_\_\_\_

The dates of patient care covered by this Authorization are: \_\_\_\_\_

### Release the Following Information:

- Discharge Summary
- Pathology Report(s)
- Emergency Record(s)
- History & Physical
- Radiology Report(s)
- Itemized Billing Statement
- Consultation(s)
- Lab Report(s)
- Operative Report(s)
- Cardiology Report(s)
- Progress Notes
- Treatment Plan(s)
- Other Records as specified: \_\_\_\_\_
- Entire Medical Record (Except for Records Concerning Highly Confidential Information).

### Release of Highly Confidential Information:

By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box:

*(please check all that apply—leaving a box unchecked may result in no information being disclosed for any purpose).*

- Mental Illness or Developmental Disability
- Abuse of an Adult with a Disability
- Sexually Transmitted Diseases (STD's)
- Genetic Testing
- Sexual Assault
- HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
- Substance (i.e., alcohol or drug) Abuse
- Child Abuse and Neglect

### This Authorization will remain in effect:

- From the date of this Authorization until: \_\_\_\_\_ (Not over one year).
- Until the Releasing Entity fulfills the request or 120 days from the date this Authorization is signed, whichever occurs earlier.

### I understand that:

- The information disclosed pursuant to the Authorization may be subject to redisclosure by the Recipient and may no longer be protected by applicable federal and Illinois law.
- I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research-related or I am to receive health care solely for the purpose of creating protected health information for disclosure to the Recipient identified in this Authorization.
- I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity in reliance on this Authorization before it received my written notice of revocation.
- I may contact Memorial Medical Center's Health Information Management Department at (217) 788-3531 or Memorial Medical Center's Privacy Office by mail at: MHS Privacy Officer, 701 N. First St., Springfield, Illinois 62781-0001; by telephone at (217) 757-7753 or through the Compliance and Privacy AlertLine at 1-800-541-9331, or by e-mail at [privacy@mhsil.com](mailto:privacy@mhsil.com).

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

Signature of Patient or Legal Representation \_\_\_\_\_ Date/Time \_\_\_\_\_  
Signature of Witness\* \_\_\_\_\_ Date/Time \_\_\_\_\_

*\*Witness' Signature is required for mental health or developmental disability treatment.*

If Signed by Legal Representative, Relationship to Patient: \_\_\_\_\_

White - MMC      Yellow - Patient



*If printed off MemorialNet, make patient a photocopy.*