

First Name

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

| Purpose of Disclosure: Requises of Patient Healthcare Treatment/Service Insurance Other: | | | | | | | // | |
|---|---|--|--|--------------------------------|--|--|---------------------|------------------|
| Lauthorize (check all that apply): Harrisburg Medical Center Herrin Hospital Memorial Hospital of Carbondale St Jospeh Memorial Hospital to disclose the below medical information to: Marine | First Name | | MI Last Name | | | Maiden Name | Date of Birth | Last 4 SS# |
| to disclose the below medical information to: Name | Purpose of I | Disclosure : 🗖 Re | equest of Patient 🔲 H | lealthcare T | reatment/Service | e 🔲 Insurance 🔲 C | ther: | |
| Specific information to be disclosed (check all that apply) Date(s) of Treatment: | | | | nter 🔲 Herrir | n Hospital 🔲 Mem | orial Hospital of Carbondale | e 🔲 St Jospeh Memo | rial Hospital |
| Discharge Summary | Name | | Street A | ddress | | City | State | Zip |
| History & Physical Pathology Report Radiology Films Laboratory Reports Itemized Bills | Specific info | rmation to be dis | sclosed (check all that a | apply) | | Date(s) of Treatment | : | |
| Emergency Room Report | □ Discharg | ge Summary | ☐ Operative Room Re | port R | adiology Reports | ☐ Progress Notes | ☐ EKG/Stress | Test |
| Your medical and billing information may include sensitive information including but not limited to the examination, diagnosis, evaluation, treatment and or rehabilitation pertaining to a) alcohol and/or substance abuse, b) HIV/Aids, c) mental/behavioral health, d) development disability, e) sexually transmitted disease (STD); f) reproductive health. I authorize disclosure of my sensitive information (check all that apply): Alcohol and/or Drug Abuse | History | & Physical | ☐ Pathology Report | □ R | adiology Films | ☐ Laboratory Reports | 5 Itemized Bi | lls |
| evaluation, treatment and or rehabilitation pertaining to a) alcohol and/or substance abuse, b) HIV/Aids, c) mental/behavioral health, d) development disability, e) excually transmitted disease (STD); f) reproductive health. I authorize disclosure of my sensitive information (check all that apply): Alcohol and/or Drug Abuse | ☐ Emerge | ncy Room Report | ☐ Consultation Repor | t 🗆 Ot | ther: | . L | | |
| Lunderstand Nave a right to revoke this authorization at any time. Lunderstand if revoke this authorization must do so in writing and present my written revocation to the Health Information Department. Lunderstand the revocation will not apply to information already released in response to this authorization. This authorization will expire on/(*date is required for disclosure of mental/behavioral health information). if do not specify an expiration date and the health information disclosed does not include mental/ behavioral health information, I acknowledge this authorization is valid for 6 months from the date of my signature. Lunderstand the information (excluding mental health information, developmental disability, alcohol and substance abuse information, and/or HIV/Aids information) being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act (HIPAA). Lunderstand authorizing the disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Lagree a photocopy of this authorization is valid as the original. Patients 12-17 years of age have authority to authorize disclosures for information pertaining to mental health and developmental disability, alcohol/drug abuse, HIV/Aids, STD's, reproductive health (abortion), criminal sexual assault or abuse. Date Check one: | evaluation, d d) developm | treatment and or nent disability, e) | rehabilitation pertaini sexually transmitted d | ng to a) alco isease (STD) | phol and/or subst ; f) reproductive | tance abuse, b) HIV/Aid | | • |
| and present my written revocation to the Health Information Department. I understand the revocation will not apply to information already released in response to this authorization. This authorization will expire on/ (*date is required for disclosure of mental/behavioral health information). If I do not specify an expiration date and the health information disclosed does not include mental/ behavioral health information, I acknowledge this authorization is valid for 6 months from the date of my signature. I understand the information (excluding mental health information, developmental disability, alcohol and substance abuse information, and/or HIV/Aids information) being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act (HIPAA). I understand authorizing the disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I agree a photocopy of this authorization is valid as the original. Patients 12-17 years of age have authority to authorize disclosures for information pertaining to mental health and developmental disability, alcohol/drug abuse, HIV/Aids, STD's, reproductive health (abortion), criminal sexual assault or abuse. Signature Patient/Patient's Legal Representative Date Check one: am the patient Date D | ☐ Alcohol a | and/or Drug Abuse | | | · · | • | mitted Reprod | ductive Health |
| information, and/or HIV/Aids information) being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act (HIPAA). I understand authorizing the disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I agree a photocopy of this authorization is valid as the original. Patients 12-17 years of age have authority to authorize disclosures for information pertaining to mental health and developmental disability, alcohol/drug abuse, HIV/Aids, STD's, reproductive health (abortion), criminal sexual assault or abuse. Signature Patient/Patient's Legal Representative Date Check one: I am the patient I am the Legal Representative of the Patient (complete a & b) a) First Name Last Name Phone Number b) Relationship to Patient: Parent Guardian Legal Representative/Agent. Witness Signature (required for disclosure for mental health and developmental disabilities) Date: Date: Date: | already rele This authori not specify a | ased in response zation will expire an expiration date | to this authorization. on// e and the health inform | _ (*date is r nation disclo | equired for discl | osure of mental/behav lude mental/ behavior | vioral health infor | mation). If I do |
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| Witness Signature (required for disclosure for mental health and developmental disabilities) Date: | | | | _ | | | Phone Numb | er |
| Date: | • | · | | | _ 0 | | | |
| | Witness Signa | ature (required for | disclosure for mental hea | alth and devel | lopmental disabilit | ies) | Date: | |
| | Witness Drint | ed Name | | | | | Juic | |

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Last Name