SIH

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

_____ ____/____/____ _____

First Name MI Last Name Maiden Name Date of Birth Last 4 SS#

Purpose of Disclosure: ☐ Request of Patient ☐ Healthcare Treatment/Service ☐ Insurance ☐ Other: _____

I authorize (check all that apply): ☐ Harrisburg Medical Center ☐ Herrin Hospital ☐ Memorial Hospital of Carbondale ☐ St Jospeh Memorial Hospital to disclose the below medical information to:

_____

Name Street Address City State Zip

Specific information to be disclosed (check all that apply) **Date(s) of Treatment**: _____

☐ Discharge Summary	☐ Operative Room Report	☐ Radiology Reports	☐ Progress Notes	☐ EKG/Stress Test
☐ History & Physical	☐ Pathology Report	☐ Radiology Films	☐ Laboratory Reports	☐ Itemized Bills
☐ Emergency Room Report	☐ Consultation Report	☐ Other:		

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	☐ HIV/Aids	☐ Mental/Behavioral Health*	☐ Developmental Disability	☐ Sexually Transmitted Disease	☐ Reproductive Health

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing 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:

☐ 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: _____

Witness Printed Name

_____

First Name MI Last Name