AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

☐ Carmi Clinic ☐ Hamilton Memorial Hospital ☐ Hamilton Memorial Clinic

To release the personal health information of:

Patient's Name: ____ Date of Birth:__________________

Address: ____ City: ________________ State: _____ Zip: ___________

Email Address: ____ Phone: ____________________________

I request that my protected health information (PHI) be disclosed to:

Recipient Name: ____ Phone: ____________________________

Address: ____ City: ________________________ State: ____ Zip: ___________

Email: _____________________________________ Phone: ____________________ Fax (Healthcare Provider Only): ____________

Release the Following Information:

❑ Immunization Record ❑ Pathology Report(s) ❑ Emergency Record(s) ❑ Lab Report(s)
❑ Radiology Report(s) ❑ Itemized Billing Statement ❑ Itemized Billing Record(s) ❑ Cardiology Report(s)
❑ Abstract/Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultation(s) and Test Result(s); Except for Records Concerning Highly Confidential Information).
❑ Other Records as specified: ____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment of alcohol or drug abuse, and behavioral or mental health services, ***for which I will need to request the Release of Mental or Behavioral Health form***. State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained by initialing next to each requested section.

______❑ Sexually Transmitted Diseases (STD's)
______❑ Sexual Assault
______❑ Substance (i.e., alcohol or drug) Abuse
______❑ Genetic Testing

_______❑ 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).

Covering the period of healthcare from: Specific Date(s): _____________________ to ___________________________;
OR Unless otherwise revoked, this authorization will expire on the following date/event/condition, not to exceed 90 days: ____. If I fail to specify an expiration date/event/condition, this authorization will expire once the releasing entity fulfills the request.

For the purpose of: ❑ Legal ❑ Insurance ❑ Personal ❑ Continuation of Care ❑ Other: _____________________________________

Disclosure Format (Paper is default if not marked). ❑ Us Mail – paper format ❑ In person Pickup ❑ Email (secure format)
❑ Fax (healthcare provider only) ❑ CD/Flash-Drive (secure format)

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to **revoke** this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address:
  - **611 S. Marshall Street**
    PO Box 429
    McLeansboro, IL 62859

  Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment, or eligibility for benefits **may not be conditioned** on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- I may contact Hamilton Memorial Hospital District's Health Information Management Department at:
  - **(618) 643 – 2361 ext. 4500**
  - Or *Hamilton Memorial Hospital District's Privacy Office* by mail at:
    - **HMHD Privacy Officer**
      611 S. Marshall Ave.
      PO Box 429
      McLeansboro, IL 62859
  - By telephone:
    - **(618) 643 – 2361 ext. 1100**
  - Compliance and Privacy Hotline:
    - **(618) 643 – 2361 Option 5**
  - By email:
    - **gsutton@hmhospital.org**

Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

_______________________________________ _______________________________

Signature of individual (age 12 or older) Date/Time

_______________________________________ _______________________________

Signature of parent/guardian (Under 18 or Disabled) Date/Time

_______________________________________ _______________________________

Signature of HIM staff person disclosing/obtaining information Date/Time

For Office Use Only

Account Number: ____________________ Photo ID Verified: ___________________

Date Request Received: ______________________ Date of Release: ______________________________