Hamilton Memorial
HOSPITAL DISTRICT

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

INSTRUCTIONS (for internal use) ☐ Record copy request only ☐ No copies requested, CoC only

1. PATIENT INFORMATION

Patient Name:_____ Birthdate:_____
Street Address:_____ SS#:_____
City, State, Zip:_____ ACCT#:_____
Maiden/Other Name(s):_____ Phone#: (home)_____ (cell) _____

I authorize the use/disclosure of my behavioral health records and/or information as follows:

2. PARTY WHO HAS MY BEHAVIORAL HEALTH RECORDS (WHO IS SENDING MY RECORDS)

☐ Hamilton Memorial/Hamilton Memorial Clinic
☐ Other:_____ Phone #: ( )_____
Street Address:_____ City, State, Zip:_____

3. PARTY OR PARTIES WHO I WANT TO RECEIVE MY BEHAVIORAL HEALTH RECORDS (WHO WILL GET MY INFORMATION)

☐ Hamilton Memorial/Hamilton Memorial Clinic
☐ Other: _____ Phone #: ( )_____
Street Address:_____ City, State, Zip: _____

4. PURPOSE OF USE/DISCLOSURE OF MY BEHAVIORAL HEALTH RECORDS AND/OR INFORMATION

☐ Medical follow-up ☐ Employment reasons ☐ Underwriting (insurance)
☐ Lawsuit ☐ Patient request (I do not wish to be more specific.)

5. THE DATES OF RECORDS AND/OR INFORMATION TO BE USED OR DISCLOSED:

☐ Records or information from:_____ to_____
[Beginning Date] [End Date]

6. DESCRIPTION OF MY BEHAVIORAL HEALTH RECORDS AND/OR INFORMATION TO BE USED AND DISCLOSED

☐ ER Record(s) including Behavioral Health
☐ Behavioral Health Office Visit(s)
☐ Hospital Records Including Behavioral Health
☐ Labs
☐ X-Rays
☐ Billing Records
☐ Other: _____

SPECIALLY PROTECTED RECORDS
(CHECK AND INITIAL THE FOLLOWING)

_____☐ Alcohol/Drug Abuse Treatment Records
_____☐ Genetics
_____☐ Sexually Transmitted Disease(s)
_____☐ HIV

7. EXPIRATION

This authorization will expire on _____/ _____ /_____ (DD/MM/YYYY).
If no date is specified, information will only be released as of the date this request was received by Hamilton Memorial/Hamilton Memorial Clinic.

8. CANCELING THIS AUTHORIZATION:

I may cancel this authorization at any time by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to Hamilton Memorial Health Information Management at the address shown at the bottom of the next page. The cancellation will take effect when Hamilton Memorial receives the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Hamilton Memorial received my letter.

Please see bottom of next page for mailing address.

9. RE-DISCLOSURE OF MY HEALTH RECORDS AND/OR INFORMATION:

I understand that the person who receives my mental health information, alcohol and drug abuse records, or HIV records may NOT disclose it to someone else without my permission, unless permitted by law.

10. EFFECT OF NOT SIGNING THIS AUTHORIZATION:

I am not required to sign this authorization in order to receive most health care services at Hamilton Memorial. However, I understand that if the ONLY reason I am seeing a Hamilton Memorial provider is to create health information for someone else's use (such as my employer), Hamilton Memorial may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, other than ordered by said employer, then I must sign this authorization in order for Hamilton Memorial to perform the pre-employment test.

11. FEES:

I may be charged a copying fee to complete this request. I may ask Hamilton Memorial for a fee estimate. If there is a fee, the bill may come from Verisma, the company that processes some health information requests for Hamilton Memorial. For questions regarding potential fees please contact the correspondence department at the number below.

12. RIGHT TO INSPECT & COPY:

I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization at a scheduled date and time.

13. MY AUTHORIZATION:

_____ _____

Signature of Patient 12 years old and over — Date Signed

_____ _____

Signature of Legal Representative or Guardian — Date Signed

_____ _____

Printed Name of Representative or Guardian — Relationship to Patient (Authority to Sign for Patient)

_____ _____

Signature of Witness to Patient's Signature — Date Signed

14. INSTRUCTIONS FOR RECORD COPY REQUESTS ONLY (CHECK ONE IF APPLICABLE):

☐ Mail record copies out to party or parties I named in #3 ☐ I will pick up records

15. RETURN THIS COMPLETED FORM **OR REVOCATION LETTER** TO:

HMHD - Health Information Management
Release of Information
611 S. Marshall Ave.
McLeansboro, IL 62859
(618) 643- 2361 ext. 4500

16. PROVIDER RELEASE NOTIFICATION: (OFFICE USE ONLY)

☐ Dr._____ has been notified of this release _____(initials/date)
☐ Dr._____ has been notified of this release _____(initials/date)
☐ HIM has notified all providers _____(initials/date)
☐ Dr._____ has denied this release_____(initials/date)

Specific instructions from Clinician:

_____

_____

_____

_____

Signature, Date, and Time

Provide Copy of Signed Form to Patient