



**AUTHORIZATION AND ACKNOWLEDGMENT
FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION**

**Authorization to disclose Protected Health Information for purposes other than Treatment, Payment, or
Healthcare Operations.**

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information for purposes other than Treatment, Payment, or Healthcare Operations as described below.

2. The following organization is authorized to make the disclosure:

- | ENTITY: | ADDRESS: |
|---|---------------------------|
| <input type="checkbox"/> Hamilton Memorial Hospital | 611 South Marshall Avenue |
| <input type="checkbox"/> Hamilton Memorial Home Health | McLeansboro, IL 62859 |
| <input type="checkbox"/> Hamilton Memorial Nursing Center | |

Name of entity maintaining the protected health information if other than Hamilton Memorial Hospital District.

3. The type and amount of information to be used or disclosed is as follows:

from (date) _____ to (date) _____

- problem list
- medication list
- list of allergies
- immunization record
- history and physical
- discharge summary – patient discharge instructions
- laboratory results
- x-ray and imaging reports
- operative reports
- consultation reports
- physician orders and/or progress notes
- 485
- visit notes
- entire record
- therapy notes
- emergency room record
- Other

4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

for the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 90 days from the date signed.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Director.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Signature of Patient or Legal Representative

Date and Time signed

If Signed by Legal Representative, Relationship to Patient

Signature of Witness