Patient's Name: _____ Phone _____
Address _____
Social Security # _____
Date of Birth: _____ Date(s) of Service: _____

1 R O I

I authorize the use or disclosure of the above named patient's health information as described below:

FACILITY: CHECK ALL THAT APPLY

❑ **Covenant Clinic** ❑ **Covenant Medical Center**
❑ **Mercy Hospital** ❑ **Sartori Memorial Hospital**

FOR THE PURPOSE OF: (Check all that apply)

❑ Continued Care ❑ Legal
❑ Insurance ❑ At Request of Patient
❑ Other (explain)_____

INFORMATION TO BE DISCLOSED:

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

❑ Record Abstract ❑ Discharge Summary
❑ History & Physical ❑ Emergency Department Record
❑ List of Allergies ❑ Medication List
❑ Immunization Record
❑ Laboratory Results from (date)_____to (date)_____
❑ X-ray and Imaging Reports from (date)_____to (date)_____
❑ Consultation Reports from (doctors' names)
_____
❑ Entire Record
❑ Other_____

FROM: _____
Address _____
City, State, Zip _____
Phone _____

TO: _____
Address _____
City, State, Zip _____
Phone _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

If the information of the following types is available, I give permission for its release: *(Client must check appropriate box[es])*

Substance Abuse	❑ Yes	❑ No
Mental Health	❑ Yes	❑ No
HIV Related Information	❑ Yes	❑ No

_____
SIGNATURE OF CLIENT OR LEGAL GUARDIAN DATE
In order for the above information to be released, you must sign here.

This authorization is voluntary. Wheaton Franciscan Healthcare will not condition your treatment on this authorization.

I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

I also understand that I have a right to view and/or receive copies of my health information and that there may be a charge for copies. In support of your privacy, Wheaton Franciscan Healthcare does not accept your blanket authorization to disclose health information of treatment not yet received unless the authorization specifically requests release of information of further treatment of the condition treated in the originally requested episode. A new authorization will be required for each new episode of care. I understand that if I refuse to authorize the disclosure of information, the information may not be released. Refer to the Notice of Privacy Practices for more information about your rights with your health information.

I understand that the information in my health record may include information relating to mental health, substance abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization automatically expires 365 days from the date this authorization is signed by the patient below unless otherwise noted

_____.

Signature of Patient or Authorized Representative _____ Date _____

If Signed by Authorized Representative, Relationship to Patient _____ Date _____

Signature of Witness _____ Date _____

If unable to sign document, give reason _____

❑ This information has been disclosed to you from records protected by Federal laws and regulations protecting substance abuse treatment program records (42 C.F.R. part 2). The Federal rules prohibit you from making any further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for the purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR HIM USE ONLY

Account #: _____
Account #: _____
Account #: _____
Account #: _____

Wheaton Franciscan Healthcare

❑ Covenant Clinic
❑ Covenant Medical Center
❑ Mercy Hospital
❑ Sartori Memorial Hospital

Authorization To Disclose Health Information

PMM 462956 10/28/10 tm