



- Covenant Clinic
- Covenant Medical Center
- Covenant Regional Services
- Mercy Hospital of Franciscan Sisters
- Sartori Memorial Hospital

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Health Record Number: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

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

**FROM:**

**TO:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**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
- HIV/AIDS
- History & Physical
- Emergency Department Record
- Substance Abuse
- List of Allergies
- Medication List
- Mental Health
- 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 \_\_\_\_\_

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. 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.

