AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

mdh

McDonough District Hospital

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
I authorize the use or disclosure of the above named individual's health information as described below:	
Release From: Clinic / Health Care Provider – (**Who** has the information you want released?) **Please list the specific hospital or clinic.**	Name: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Release to: Receiving Party (**Where** do you want the information sent? **Who** may have the information?)	Name: _____ Attention to: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number (**URGENT PATIENT CARE ONLY**): _____
Information to be Released (**What** do you want sent or released? Check the appropriate box.)	Indicate date(s) of service: _____ ☐ **My entire record (except for records concerning highly confidential information)** Only record types checked below: ☐ Discharge Summary / Note ☐ Radiology Reports ☐ Emergency Record(s) ☐ History & Physical Exam ☐ Rehab Records (PT/OT/ST) ☐ Medication Records ☐ Immunization/Allergy Record ☐ Operative Reports ☐ Laboratory Reports ☐ Progress Notes / Clinic Notes ☐ Pathology Reports ☐ Consultation ☐ Treatment / Care Plan ☐ Other Records – specify record type(s): _____ **By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and / or disclosure of this information:** **MUST BE CHECK MARKED & INITIALED TO BE VALID:** ☐ Mental Health Information _____ ☐ HIV / AIDS Testing or Treatment _____ ☐ Sexually Transmitted Diseases _____ ☐ Developmental disabilities Information _____ ☐ Genetic Testing _____ ☐ Alcohol and / or Drug Abuse _____ ☐ Sexual Assault _____ ☐ Abuse or Neglect _____ OPTIONAL Limits – Disclose only records related to following: Date(s) of service: _____ Injury / Illness: _____
Release Instructions (**When** do you want the information?)	Date information is needed: _____ **(NOTE: PLEASE ALLOW 30 DAYS FOR PROCESSING)**
Purpose of Release (**Why** is it needed?)	☐ Continuing Care ☐ Transfer of Care ☐ Social Security Appeal ☐ Insurance Application ☐ Personal Use or Review ☐ Social Security Disability Determination ☐ Litigation / Legal ☐ Other: _____ ***Fees may be charged in accordance with Illinois State Statutes.**
This authorization will remain in effect:	From the date of this authorization until _____, unless otherwise revoked. If I fail to specify an expiration date, this authorization will expire **1 year** from the date of signature on this form.

I understand that:

- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization for any reason, which will **prevent disclosure of information.**
- The above persons or organization authorized to make the requested disclosure **may not restrict or condition treatment** or payment upon completion of this form.
- I have the **right to inspect or copy the information** to be used or disclosed.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information **may not be protected** by federal or Illinois privacy laws.
- I have **the right to revoke** this authorization in writing at any time. If I wish to do so, I must send written notification to McDonough District Hospital, 525 E. Grant St., Macomb, IL 61455. The revocation will not apply to information that has already been released in response to this authorization.
- A photocopy / fax of this authorization will be treated in the same way as an original.
- If I have questions about disclosure of my health information, I may contact the MDH privacy officer at (309) 836-1580.

_____ _____

Patient / Legal Guardian Signature Date Relationship to Patient if Signed by Authorized Representative

_____ _____

Witness Signature Date

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REV: 4.2.19 nld **MMG-58** 9528146 EFF: 4.2.19

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Directions for Completion of Form

McDonough District Hospital

REV: 4.2.19 nld **MMG-58** 9528146 EFF: 4.2.19

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Clinic / Health Care Provider: Identify which clinic or Healthcare Provider you are seeking information from. **Please be specific** in your request.

Receiving Party: Identify the full name / business, address, phone and contact information with the name of the individual who is to receive the information. Please note: It is MDH policy **NOT** to fax or email patient information except for direct patient care requirements (e.g. to a doctor or clinic). *Please allow 30 days for all requests to be processed and sent to the recipient.*

Information to be Released: This section gives us the instructions for what information you want released. If you select "Entire Record" your entire record will be provided for a specific visit date or all dates. Information in the **bolded box** WILL NOT be released unless specifically indicated by checking the box and initialing in the area provided. It is very helpful if you identify the date or range of dates, needed by the requestor.

Release Instructions: Please indicate the date records are needed and allow 30 days for processing.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Authorization Effect Date: Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event. The authorization is revoked at your written direction to our organization. Be advised that information already released is exempt from revocation.

Calculating the amount allowed under Illinois law:

Handling Fee* (***cannot charge this for records provided directly to the patient / personal representative. If the records are going to entities beyond the patient / personal representative, such as attorneys or health plans, the handling fee may be charged.)			$28.44
Per page charges:			
	Pages 1-25	$0.75 per page	$
	Pages 26-50	$0.50 per page	$
	Pages 51 and over	$0.25 per page	$
	Flash Drive	$6.50 - $20.00	$
Mailing Charges			$
		TOTAL:	$

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