Sarah Bush Lincoln

DATE RECEIVED: _____

TO: ☐ Sarah Bush Lincoln Health Center ☐ Lincolnland Home Care ☐ Lincolnland Home Medical Equipment
☐ Physician Clinic: _____ ☐ Lincolnland Hospice ☐ Other: _____
☐ East Central Illinois Breast & Cervical Cancer Screening Program

You are hereby authorized to release protected health information to: *(Who the protected health information is going to)*

_____
(Name of Party to Receive Protected Health Information)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

Release protected health information of: _____ _____ / _____ / _____
(Name of Patient) (Birthdate xx / xx / xxxx)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

The patient or authorized representative authorizes the use or disclosure of protected health information to be released. Patient or authorized representative must initial the item, which needs additional protected health information disclosed.

____ Mental Health/Psychiatric ____ Psychotherapy Notes ____ Alcohol and/or Drug Related ____ Genetic Testing
____ Abuse ____ HIV/AIDS ____ Other Communicable Disease

Date of Care: _____ Medical Record #: _____ Account #: _____

The Type of protected health information to be used or disclosed is as follows:

☐ Diagnosis / Procedures ☐ Discharge Summary ☐ Emergency Room Record ☐ X-ray Reports ☐ Delivery Tickets
☐ History & Physical ☐ Registration Sheet ☐ Pathology Report ☐ X-ray Films ☐ Pick up Tickets
☐ Report of Operation ☐ Pertinent Data ☐ Lab Reports ☐ Prescriptions ☐ Service Reports
☐ Provider Progress Notes ☐ Entire Admission ☐ EKG Reports ☐ Certificates of Medical Necessity
☐ Other (Specify) _____

Method of release: ☐ Photocopies ☐ Verbal ☐ FAX ☐ CD ☐ Film
For the purpose of: ☐ Continued Treatment ☐ Evidence of Care ☐ Legal

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other healthcare provider records may be a part of my hospital record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited in accordance with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. 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 the insured with the right to contest a claim under my policy. Unless otherwise revoked in writing, this authorization will expire 1 year from date signed. The date of authorization expiration will be _____ .

Signed _____ **Date** _____ **Time** _____
(Patient or Legal Representative)

If Legal Representative, document relationship to Patient: _____

Signed _____ **Date** _____ **Time** _____
(Witness)

Processed By: _____ **Date:** _____ **Number of pages:** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION