HSHS St. Elizabeth's Hospital

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zip _____

Date of Birth _____ Daytime Phone _____ Previous Name(s) _____

2) AUTHORIZES: **St. Elizabeth's Hospital**

One St. Elizabeth's Boulevard

O'Fallon, IL 62269

_____
Fax # of Health Care Provider

3) TO DISCLOSE TO:

❑ Self, Delivery Options: ❑ Pick up ❑ Mail to address above ❑ View on−site ❑ Electronic Format

❑ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send To: ❑ _____
Name of Health Care Provider/Plan/Other

_____
Address Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ If left blank, only information from the past two (2) years will be disclosed. (Month/Year) (Month/Year) Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

❑ Abstract of record/Pertinent records ❑ History & physical ❑ Discharge summary
❑ Emergency Department report ❑ Consultation reports ❑ Operative reports
❑ Radiology/Imaging reports ❑ Laboratory/Pathology ❑ EKG
❑ Radiology/Imaging films/CD ❑ Progress notes _____ ❑ Billing records _____

Specific records and/or information as follows: _____

_____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

❑ Alcohol/Drug Abuse ❑ HIV Test Results ❑ Mental Health/Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: _____

Or if this item is left blank, the authorization will expire in (1) year from the date signed.

7) PURPOSE (check all that apply −copy fees may apply): ❑ Patient Request ❑ Continuing Care

❑ Legal Investigation/Action ❑ Insurance Eligibility/Benefits ❑ Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the right to inspect and/or receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that if I agree to sign this authorization, I will be provided with a copy of it. I understand that I may be charged a fee for record copies. I understand that I am under no obligation to sign this form. Treatment, payment enrollment or eligibility for benefits may not be based upon my decision to sign this authoriation. Authorization may be needed to release information to payers for certain mental health services and/or HIV testing. If I refuse to sign the authorization form for this purpose I understand that I may be responsible for paying the entire bill for these services. I also understand that I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that the information used and/or disclosed pursuant to this Authorization may be subject to re−disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT: _____ Date: _____ and/or

SIGNATURE OF PATIENT/LEGAL REP: _____ Date: _____

If signed by a person other than the patient, complete the following:

1) Individual is: ❑ a minor ❑ legally incompetent or incapacitated ❑ deceased
2) Legal authority: ❑ parent* ❑ legal guardian ❑ activated POA for Health Care ❑ next of kin/executor of deceased

*By signing above, I hereby declare that I have not been denied physical placement of this child.

OFFICE USE ONLY: Signature/ID verified: ❑ Yes ❑ No Date/Time Released: _____

# of pages released: _____ Completed by: _____ Medical Record Number: _____

Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original