Authorization For Release of Information

Pinckneyville Community Hospital
5383 State Route 154, Pinckneyville, IL 62274

Patient Name: _____ Date of Birth: _____

Address: _____ Account #: _____

_____ Med Rec #: _____

1. I authorize the use or disclosure of the above-named individual's health information, as described below.

2. The following departments are authorized to make the disclosure: ☐ PCH Medical Records Department
   ☐ Family Medical Center Business Office ☐ Provider other than Pinckneyville Community Hospital:

   _____
   Name/Address/Phone

3. Please specify the type and amount of information to be used or disclosed:

   ☐ History & Physical ☐ Immunization Record ☐ Medication List ☐ Allergy List
   ☐ Discharge Summary ☐ Consultations ☐ Itemized Bills ☐ Problem List
   ☐ Laboratory Reports: Date(s) of Service _____ to _____
   ☐ X-ray/Imaging Films/Reports: Date(s) of Service _____ to _____
   ☐ Other _____

4. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. The following items must be checked and initialed in order to be included in the use and/or disclosure of other health information:

   ☐ HIV/AIDS-related treatment _____ (Initial) ☐ Drug/alcohol diagnosis/treatment/referral _____ (Initial)
   ☐ Other sexually transmitted diseases _____ (Initial) ☐ Mental Health _____ (Initial)

5. This information may be disclosed to and used by the following individuals or organizations:

   Name: _____

   Address: _____

   Phone: _____ Fax: _____

6. This information is being disclosed for the following purpose(s): ☐ Personal ☐ Continuation of Care
   ☐ Other _____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the department selected above. 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 my insurer with the rights to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days or _____.

8. I understand that once the information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act.

Signature of Patient
Or Legal Representative _____ Date _____

If signed by legal representative, relationship to patient _____

Signature of Witness _____