Authorization to Disclose Health Information

I hereby authorize Sparta Community Hospital District
818 E Broadway, PO Box 297, Sparta, IL 62286 – 618-443-2177 x3336 – Fax: 618-443-1380

to disclose my individually identifiable health information as described below.

_____

Patient Name DOB/SSN MR#

Name/Address of person(s) or organization(s) to receive the records:

_____

_____

From the following date(s):_____

For the purpose of
- □ continued medical care
- □ payment of medical balances
- □ at the request of the individual
- □ workman's compensation
- □ legal action
- □ Other_____

Please mark (x) the specific information to be disclosed:

_____ Discharge Summary/Resume	_____ History & Physical	_____ Consultations
_____ Operative Report	_____ Pathology Report	_____ Lab Reports
_____ Radiology Reports	_____ EKGs	_____ Therapy Notes
_____ Physician Progress Notes	_____ Emergency Room Report	_____ Entire Record
_____ Films_____	_____ Itemized Statement	_____ Clinic Records

_____ Accounting of Disclosure for dates:_____
_____ Other:_____

Understandings and Agreements of Requestor:
1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.
(_____initials required to release this information)
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. This authorization will expire based on the following date, event or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.
4. This authorization is voluntary and treatment at this facility is not contingent on signing this authorization.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by this facility.
6. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records which has been set by Illinois law. Fees subject to annual adjustments.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship of Legal Representative Witness

_____
Office Use Only

Records released by:_____Date_____Time_____