MORRIS HOSPITAL
& HEALTHCARE CENTERS
150 West High Street
Morris, IL 60450
www.morrishospital.org
People You Know. Extraordinary Care.

AUTHORIZATION

TO USE AND DISCLOSE HEALTH INFORMATION

2 R O I

Patient's Name:_____ **Date of Birth:**_____

Address:_____

Telephone Number: (_____)_____-_ _____Social Security Number (last 4 Digits:XXX-XX-_____

I _____, do hereby authorize

□ Morris Hospital □ Morris Hospital Healthcare Centers □ CIOX

□ Other _____

to release the following individually identifiable health information (**check all that apply**):

____ Face Sheet ____Operative Report ____Immunization Record ____Physical

____Discharge Summary ____Pathology Report ____Progress Notes ____Lab Reports

____Emergency Record ____History and Physical ____Consultations ____Office Visits

____Cardiology Reports ____Physicians Orders ____Complete File

____Radiology (circle one) Reports (and/or) Image ____Other (Specify):_____

REGARDING DATES OF SERVICE from _____ to _____ are authorized for release.

Under Illinois law, you must separately and expressly authorize the release of any of the following **Highly Confidential** information. **By placing my INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed.

____HIV/AIDS related information ____Substance Abuse (Drug/Alcohol) ____Sexual Assault

____Mental Health Information ____Genetic Testing ____Venereal Diseases

____Child Abuse/Neglect ____Abuse of Adult with a disability

RELEASE RECORDS TO: (Name & Address to disclose or send records) _____

_____

PURPOSE OF DISCLOSURE:

____Transfer of Care ____Insurance ____Legal Consultation ____Consultation with Physician

____Treatment Plan/Coordination of Care ____Self ____Other (specify):_____

METHOD OF DISCLOSURE: ____Paper Copy ____Disk _____Other:_____

Office Use Only:

MR# or DD# _____ Release Completion Date: _____ By :_____(mnemonic)

I understand that Morris Hospital may not and will not condition health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits, upon my signing this authorization for the requested use and disclosure. I further understand that if the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In such a case, the information may be re-disclosed by the recipient to others for other purposes. I understand that I may, at any time, inspect or obtain a copy of the information about me that will be used and disclosed, as described below, by mailing a written request to the address given below or presenting it in person at any Morris Hospital facility.

I understand that my decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and that I may refuse to sign this form. I understand that I may revoke this authorization, in writing, at any time. However, such a revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law. I may take such a written revocation by mailing it to the address given below or presenting it in person at any Morris Hospital facility. I also understand that I may request a copy of Morris Hospital's Notice of Privacy Practices, or ask any other questions, by calling Morris Hospital's AlertLine, at 1-800-93-ALERT, or the Medical Records Department of the Morris Hospital facility where I receive treatment, at any time, in order to learn more about how information about me is used or disclosed by Morris Hospital or about revocation of this authorization.

Unless revoked by me sooner, or limited or restricted to a shorter time period by applicable law, this authorization shall be effective for _____ days/months/years *(complete blank and circle appropriate period)* after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below, and if signing in person at a Morris Hospital facility, I will ask for such a copy, if one is not provided, before I leave.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

_____ _____

Signature of Patient or Legally Authorized Representative *Date*

_____ _____

If not Patient, then Relationship of Legally Authorized Representative to Patient *Date*

_____ _____

Signature of Witness *Date*

RETURN FORM TO:

Morris Hospital Attn: Medical Records
150 W. High St., Morris, Illinois 60450
Telephone: (815) 942-2932, ext. 7728
Fax: (815) 942-0839

Patient Label

****** Notice to Recipients of Alcohol & Drug Abuse Information: The confidentiality of alcohol and drug abuse patient records maintained by Morris Hospital, and disclosed to you pursuant to this under this authorization, is protected by Federal law and regulations *(see* 42 U.S.C. § 290dd-3 and 290ee-3, and 42 C.F.R. pt. 2). Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, unless: (a) the patient consents in writing (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime. Suspected violations should be promptly reported to appropriate authorities, in accordance with Federal regulations. Federal laws and regulations do not protect any information about a crime committed by a patient or about any threat to commit a crime. Federal laws and regulations also do not protect information about suspected child abuse or neglect from being reported under State law or regulations to the appropriate State or local authorities.