Memorial Care

DECATUR MEMORIAL MEDICAL GROUP
HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

To release the personal health information of:

Patient name: _____ Phone: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

To release to: Recipient: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

To release from: Releasing Entity: _____ Phone: _____

The purpose of this disclosure is: ☐ At the request of the individual ☐ Other: _____

The dates of patient care covered by this Authorization are: _____

Release the following information:

☐ Discharge summary ☐ Pathology report(s) ☐ Emergency record(s) ☐ History and physical
☐ Radiology report(s) ☐ Itemized billing statement ☐ Consultation(s) ☐ Lab report(s)
☐ Operative report(s) ☐ Cardiology report(s) ☐ Progress notes ☐ Treatment plan(s)
☐ Other records as specified: _____
☐ Entire medical record (except for records concerning highly confidential information)

Release of Highly Confidential Information:

By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box:

(Please check all that apply—leaving a box unchecked may result in no information being disclosed for any purpose.)

☐ Mental illness or developmental disability
☐ Sexually transmitted diseases (STDs)
☐ Sexual assault
☐ Substance (i.e., alcohol or drug) use
☐ Child abuse and neglect
☐ Abuse of an adult with a disability
☐ Genetic testing
☐ HIV/AIDS testing or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

This Authorization will remain in effect:

☐ From the date of this Authorization until: _____(not over one year)
☐ Until the Releasing Entity fulfills the request or 120 days from the date this Authorization is signed, whichever occurs earlier.

I understand that:

- The information disclosed pursuant to the Authorization may be subject to redisclosure by the Recipient and may no longer be protected by applicable federal and Illinois law.
- I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research-related or I am to receive healthcare solely for the purpose of creating protected health information for disclosure to the Recipient identified in this Authorization.
- I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately except to the extent the Releasing Entity acted in reliance on this Authorization before it received the written notice of revocation.
- I may contact Memorial Health (MH) Health Information Management department at 217–876–2500 or MH Privacy Office by mail at: MH Privacy Officer, 701 N. First St., Springfield, Illinois 62781–0001; by telephone at 217–757–7753 or through the Compliance and Privacy AlertLine at 800–541–9331; or by email at himroi@mhsil.com.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

_____	_____	_____	_____
Signature of patient or legal representation	Date/time	Signature of witness*	Date/time

** Witness signature is required for mental health or developmental disability treatment.*

If signed by legal representation, relationship to patient: _____

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I understand that once the releasing entity discloses my health information to the recipient, the releasing entity cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that the releasing entity may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that the releasing entity may deny this request under limited circumstances as provided for under federal and Illinois law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed healthcare practitioner selected by the releasing entity who did not participate in the releasing entity decision to deny my request.

I understand that I may at any time make a written request to the releasing entity to inspect and/or obtain a copy of my health information, and that the releasing entity will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Memorial Health; except, however, if my treatment at Memorial Health is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Memorial Health may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the releasing entity's records release department. The revocation will be effective immediately upon the releasing entity's receipt of my written notice, except that the revocation will not have any effect on any action taken by the releasing entity in reliance on this Authorization before it received my written notice of revocation.

I may contact MH Health Information Management department at 217–876–2500 or MH Privacy Office by mail at: MH Privacy Officer, 701 N. First St., Springfield, IL 62781–0001; by telephone at 217–757–7753 or through the Compliance and Privacy AlertLine at 800–541–9331; or by email at himroi@mhsil.com.