CARLINVILLE AREA HOSPITAL

Authorization to Use and Disclose Protected Health Information

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: ( ) _____ Date of Birth: _____

Information to be Used/Disclosed

Inpatient Date(s): _____ Outpatient Date(s): _____

Specific information to be released: _____

_____

Highly Confidential Information to be Used/Disclosed

I specifically authorize the use/disclosure of the following category(ies) of "highly confidential information" as indicated below:

__ Abuse of an Adult with a Disability
__ Child Abuse & Neglect
__ HIV/AIDS Testing or Treatment
__ Genetic Testing
__ Other (specify): _____
__ Mental Illness or Developmental Disability
__ Sexual Assault
__ Sexually Transmitted Diseases (STD's)
__ Substance (i.e. alcohol, drugs) Abuse

Recipient of Information

Name of person or class of persons to whom health information may be disclosed: (specify doctor, attorney, family member, employer, insurance company, self, etc.): _____

_____

Address of Recipient: _____
Street City State Zip

Term – This Authorization will remain in effect:

__ From the date of this Authorization until the _____ day of _____, 200____. (not over 120 days)
__ Until the hospital fulfills this specific request or 120 days from this request, whichever comes first.
__ Until the following event occurs: _____

Purpose – I hereby authorize Carlinville Area Hospital to use/disclose my health information, including any "highly confidential information" selected above, during the term of this Authorization for the following specific purpose(s):

__ Continuing Medical Care __ Employment __Insurance __ Legal Purposes
__ Military __ Personal Use __ School __ Social Security
__ Other (specify): _____

- I understand that if my health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I understand that I have a right to revoke this Authorization at any time. My revocation must be submitted in writing to the hospital's Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use/disclose my health information have acted in reliance upon this Authorization.
- I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I understand that I may make a written request to inspect and/or obtain a copy of my health information.
- I have read and understand the terms of this Authorization, and have received a copy of this Authorization. I hereby knowingly and voluntarily authorize Carlinville Area Hospital to use and/or disclose my health information in the manner described above.

_____ _____
Patient/Parent/Guardian/Personal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date