Carlinville Area HOSPITAL & CLINICS

Carlinville Area Hospital & Clinics

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ Phone: (___) _____
Last First Middle

Address: _____ Date of Birth: _____
Street City State Zip

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
- ❑ Mental Illness or Developmental Disability
- ❑ Sexual assault
- ❑ Sexually Transmitted Diseases (STD's)
- ❑ Substance (i.e. alcohol, drugs) Abuse
- ❑ Other (specify): _____

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 _____, 20____. (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 & Clinics 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 & Clinics to use and/or disclose my health information in the manner described above.

_____ _____
Patient/Parent/Guardian/Personal Representative Signature Date

_____
Relationship to Patient

_____ _____
Witness Signature Date