We're here, for you. FHN	**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**	For Office Use Only: Patient MRN: _____

PATIENT INFORMATION :(Please print clearly). All information must be provided.

Full Legal Name: _____**Date of birth**: _____/_____/_____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

Telephone Number: ( ) _____

INFORMATION TO BE RELEASED FROM:

☐ FHN Memorial Hospital *1045 W Stephenson St.* *Freeport, IL 61032* *Phone: 815-599-6110* *Fax: 815-599-6544*	☐ FHN Stephenson Street	☐ FHN Hospice	☐ Other Facility/Physician:
	☐ FHN Burchard Hills	☐ FHN Fastcare	_____
	☐ FHN Highland View	☐ FHN Cancer Center	_____
	☐ FHN Community Healthcare	☐ Any and all FHN locations	_____

INFORMATION TO BE RELEASED TO:
Agency/Facility/Another Person/Self:

_____

Address: _____City:_____ State: _____ Zip:_____

Phone: _____Fax:_____

INFORMATION TO BE RELEASED: (check applicable categories)

☐Medication List	☐ Allergy List	☐ Immunizations	☐Office/Progress Notes
☐ Pathology Reports	☐Lab Reports	☐ Radiology Reports	☐Radiology Films/Images
☐Discharge Summary	☐Operation Report	☐ History & Physical	☐ ER Record

☐Other (Please Specify):_____

CONCERNING THE CARE OF THE ABOVE PATIENT FROM DATES _____TO _____

PURPOSE FOR NEED OF DISCLOSURE: (check all applicable categories) **Please note: records for continuing of medical care will be faxed directly to your provider.**

- ☐ Continuing of medical care **(will be faxed directly to your provider)**
- ☐ Personal
- ☐ Legal
- ☐ Insurance Eligibility/Benefits
- ☐ Referral to specialist [o Second opinion o Provider initiated o Services not available]
- ☐ Changing to another provider outside of FHN
  Please mark the reason why you are leaving FHN:
  - o Scheduling issues
  - o Specialty not available
  - o Dissatisfied with provider
  - o Dissatisfied with office staff
  - o Fee too high

  Other:_____

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 ☐Abuse Of An Adult With A Disability ☐ Sexual Assault ☐Child Abuse/Neglect

☐ Sexually Transmitted Diseases (Std's) ☐ Genetic Testing ☐ Substance (I.E., Alcohol Or Drug) Abuse

☐HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or recorded, regardless of whether the results if such tests were positive or negative.

I understand that this authorization will expire on _____*(Insert expiration date or event, not over one year)*. If I do not specify an expiration date or event, this authorization will expire ninety (90)days from the date on which I signed this authorization. Any additional requests needed, which are not noted above will require a new completed form.

PLEASE READ THE FOLLOWING CAREFULLY:
I understand the protected health information that I am Authorizing to be released is privileged and confidential and may be disclosed only upon my consent except as permitted by law.

I understand there may be times when it will be necessary to fax my protected health information to other providers. I consent to the use of fax transmission of any/all of my protected health information at the discretion of the provider. *I understand* that using the fax method of transmission may increase the risk of accidental disclosure of confidential protected health information to unauthorized parties. I hereby release this provider from any and all liability for accidental disclosure arising out of any such transmission. The sender of my protected health information shall not be held responsible for the completeness, legibility, or any omissions occurring in the course of copying and/ or transmitting of any/all of my protected health information.
_____ I do not wish to have my protected health information faxed.

REVOCATION
I understand that I may revoke this Authorization in writing at any time, except to the extent information was released or other action taken in reliance on it, or if obtained as a condition of insurance coverage and the insurer has legal right to contest a claim or policy. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to Medical Records Department, FHN, 1045 W. Stephenson, Freeport Illinois, 61032.

CONDITIONS
I understand that, with certain exceptions, health care providers and others may not condition treatment, payment, or enrollment or eligibility for health plan benefits, on obtaining an authorization. Exceptions may exist if authorization was sought for research-related treatment, for health care solely to create information to be disclosed to a third party (such as for a pre-employment or pre-enrollment physical), or health plan enrollment or eligibility. If such activity was conditioned on this Authorization, I understand that refusing to sign it may result in the refusal of such treatment, payment, or other activity. I understand that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for the underlying services.

REDISCLOSURE
I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.

SENSITIVE INFORMATION
I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information, and that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

REFUSAL
I understand that I may refuse to sign this Authorization, and represent that no person has coerced or imposed any inappropriate conditions on my providing this Authorization. If I refuse to sign this authorization, my requested protected health information will not be released, except as permitted by law.

RELEASE
I hereby release and hold harmless FHN, FHN Memorial Hospital, affiliated organizations, clinics, behavioral health and other centers and their respective staff, providers, directors, officers, employees, agents, successors assigns and attorneys, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure or use of the information as identified above.

_____ _____ _____
Signature of Patient or Legal Representative Date Print Name

_____
If signed by person other than the patient, relationship or authority to act for the patient

_____
Signature of Witness Date

FOR OFFICE USE ONLY

RECORDS PICK UP LOCATION & DATE:_____ Staff Member Name _____
RECORDS SENT DATE:_____ Staff Member Name _____