St. Margaret's Health
St. Margaret's Hospital
SMP Health System

600 East First Street
Spring Valley, IL 61362
(815) 664-5311
(815) 223-5346
www.aboutsmh.org

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record No. _____ X-Ray No. _____

Date of Birth_____________ Address: _____

Email Address: _____

1.I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Name of person_____; _____ Clinic or Institution

Address _____ Phone Number _____

3.The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

__ Consultation Report
__ Diagnostic Films
__ Diagnostic Reports
__ Discharge Summary
__ EEG __ Medication Sheets
__ Nurses Notes
__ Facesheet
__ History & Physical
__ Immunization Record
__ Laboratory Tests
__ Entire Record
__ ER Record
__ Pathology Report
__ Physician Orders
__ Progress Notes
__ Pulmonary Function Test

_____Electronic _____Paper

Films/Other: _____

Chart Numbers: _____

(all that apply)

4.I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5.This information may be disclosed to and used by the following individual or organization:

TO: Address: _____ for the purpose of:

_____ PICK UP DATE:_____

6.I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in three months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIPAA Compliance Officer at (815) 664-1549.

8. I understand that by signing this document it does not mean that verbal results will be released to me over the phone or in person.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

*This facility uses a professional correspondence photocopying service to process requests for release of information. We authorize this service to access medical records to carry out its responsibilities as an agent of this facility. June 2013 F:\USERS\mr549\hipaa consent for treatment form.doc