SIHF HEALTHCARE
YOUR HEALTH. OUR MISSION.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____

ADDRESS:_____

SSN:_____ DATE OF BIRTH:_____

I hereby authorize use or disclosure of protected health information about me as described below.

FROM:	TO:
_____	_____
Facility	Company or Individual
_____	_____
Street Address	Street Address
_____	_____
City/State/Zip	City/State/Zip
	_____
	Phone/Fax #

The purpose of this request is:_____

For the dates of service: _____ to _____

Release the Following Information:

☐Complete Health Record ☐Consultation Report ☐History & Physical Exam

☐Immunization Record ☐Laboratory Test Results ☐Nursing Notes

☐Operative Note ☐Physician/Provider Notes ☐Billing Statement/Itemized Bill

Release of Highly Confidential Information:

By checking any box listed below in the category of Highly Confidential Information, I ***specifically authorize*** the use and/or disclosure of the record considered Highly Confidential Information:

(***please check all that apply – leaving a box unchecked will result in that information not being disclosed***)

☐HIV/AIDS Testing or Treatment Records ☐Mental Health Treatment Records

☐Developmental Disabilities Treatment Records ☐Psychotherapy Notes

☐Substance Abuse Treatment Records (Alcohol/Drug) ☐Sexually Transmitted Disease (STD) Records

SIHF HEALTHCARE
YOUR HEALTH. OUR MISSION.

This Authorization will remain in effect (please check one):

☐From the date of this Authorization until:_____ (not to exceed one year)

☐Until Southern Illinois Healthcare Foundation fulfills this request

☐Until the following event occurs:_____

I understand that:

- The information disclosed pursuant to the Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal and state 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 health care solely for the purpose of crating 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 upon receipt by Southern Illinois Healthcare Foundation, except that the revocation will not have any effect on any action taken by Southern Illinois Healthcare Foundation in reliance on this Authorization before it received my written notice of revocation.
- I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation.

I have read and understand the terms of this Authorization. By my signature, I hereby knowingly and voluntarily authorize Southern Illinois Healthcare Foundation to use or disclose my health information in the manner described above.

_____ _____ _____
Patient Signature Date Witness*

If the patient is a minor or is otherwise unable to sign this Authorization, the patient's Personal Representative must sign.

_____ _____ _____
Authorized Personal Representative Date Relationship to Patient

_____ _____
Witness* Date

*Witness signature required for release of Mental Health or Developmental Disability Information.