Touchette
REGIONAL HOSPITAL

5900 Bond Avenue
Centreville, Il 62207
ATTN: Health Information

RELEASE OF PROTECTED HEALTH INFORMATION and DISCLOSURE AUTHORIZATION

Having been fully informed of the circumstances in connection with the request for information from my clinical record, I hereby authorize & request Touchette Regional to release and disclose the following protected health information:

PATIENT NAME: _____ **DATE OF BIRTH:** _____
(Last, first, initial) (MM/DD/YYYY)
Patient unable to sign: ☐Unresponsive ☐ Verbal Authorization
☐ I consent to my photo being taken for release of records. **Initial here**_____

Release to: Name: _____

Address: _____

Phone/Fax Number: _____

Obtain from: Name: _____

Address: _____

Phone/Fax Number: _____

DISCLOSURES: Hospitalization Dates: _____

PURPOSE of disclosure:(Check One)
☐Insurance Claim ☐Medical ☐Personal ☐Legal Counsel ☐Investigative ☐**Disability** ☐**Other: (Please Specify)**_____.

I specifically request the release and disclosure of the following protected health information:
☐Face Sheet ☐Newborn Data Sheet ☐Consultation ☐Discharge Summary
☐Surgical/Delivery Report ☐History/Physical ☐Physician's Orders/Notes
☐Laboratory/Pathology Report ☐Physical Therapy ☐Emergency Room
☐Ultrasound/Sonogram/X-ray/Scans (CAT, Brain, Lung etc) and/or films
☐EKG/Echo Reports/Stress Test/24-Hour Holter Monitor ☐Nurses' Notes
☐Respiratory (Pulmonary) Therapy ☐Complete Records
☐Other (Please Specify):_____

DISCLOSURES REQUIRING SPECIAL AUTHORIZATION (PLEASE INITIAL):
Alcohol/Drug Abuses, _____Sexually transmitted diseases/HIV results, _____and
Any psychological assessments _____.

ATTENTION: Once the above information has been released pursuant to this Authorization it may no longer be protected by Federal and/or State law or regulations; and may no longer be deemed "CONFIDENTIAL". Signature below acknowledges that I understand:

- I may revoke this authorization in writing at any time with the exception to the extent that action has been taken on this authorization.
- I further understand that this authorization shall expire without my express revocation, ninety (90) days from the above date.
- I understand that I am voluntarily signing this authorization, that I have the right to refuse to sign this authorization and that the information that is released will no longer be protected under the federal privacy laws.
- I have a right to request a copy of this authorization, inspect or obtain a copy of the information to be disclosed and that Touchette Regional Hospital may assess reasonable fee that comply with the federal and state laws.

SIGNATURES: I agree to the above information and authorize Touchette Regional Hospital to disclose the above information to the designated individuals.

Patient/Legal/Guardian Signature:_____Date_____
Legal relationship to patient: _____
Witness: Name: _____Date_____
Medical Record Use Only: TRH Correspondence Employee, _____
(618-332-5423) Number of Pages: _____Charges_____Amount Paid_____
Date Sent_____Physician(s)'Name(s):_____

Please forward completed authorization or correspondence to TRH Health Information Dept at the address above.
F_UVHI#001;#114;#133
R: 12/18