



MEDICAL RECORD #: \_\_\_\_\_

**Instructions:** The patient or patient's Personal Representative must complete this form when protected health information will be disclosed to a third party, i.e., someone other than the patient/Personal Representative. For disclosures to the patient/Personal Representative, the Patient Access Request form (C760-018) must be used.

### PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: \_\_\_\_\_ / /  
Last First MI Date of Birth

The undersigned hereby authorizes disclosure of protected health information

|                           |                           |
|---------------------------|---------------------------|
| <b>FROM:</b>              | <b>TO:</b>                |
| _____                     | _____                     |
| Institution or Individual | Institution or Individual |
| _____                     | _____                     |
| Street Address            | Street Address            |
| _____                     | _____                     |
| City/State/Zip            | City/State/Zip            |
| _____                     | _____                     |
|                           | Phone/Fax #               |

The purpose/need for the information is: \_\_\_\_\_

**As to mental health or developmental disability information, only information relevant to the purpose for which disclosure is sought may be disclosed.**

**Information to be disclosed**

- Medical Record
- Billing Record
- Designated Record Set
- X-ray Films
- Other: \_\_\_\_\_

**Dates of service to be disclosed**

- Specific Date: \_\_\_\_\_
- Range of Dates: \_\_\_\_\_
- Any and All

**Disclosures Requiring Special Authorization**

By marking any of the boxes below, I specifically authorize the use or disclosure of information containing these categories of highly confidential information:

- Mental Health or Developmental Disabilities
- Substance Abuse (Drug/Alcohol)
- HIV/AIDS Testing or Treatment
- Sexually Transmitted Diseases

This authorization will expire 180 days from the date of the signature unless a date or event prior to 180 days is specified: \_\_\_\_\_

(Enter the date or event that you request this authorization to expire)

**Do Not Write Below This Line**

**AUTHORIZATION FOR DISCLOSURE**



**My signature below acknowledges that I understand that:**

- If I refuse to authorize disclosure of this information, the following are the consequences (specify if any):

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- I have the right to inspect or obtain a copy of the information to be disclosed.
- Illinois and federal laws prohibit third parties from redisclosing mental health, developmental disability, and substance abuse treatment information. For other information, I understand that once Memorial discloses my health information to the recipient, Memorial cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.
- I may refuse to sign or, at any time, may revoke this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Memorial; except, however, if my treatment at Memorial is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, Memorial may refuse to treat me if I do not sign this Authorization.
- This Authorization will remain in effect until the term of this Authorization specified herein expires or I provide a written notice of revocation for this Authorization. A Notice of Revocation from can be obtained by contacting Memorial's Medical Record Department. The revocation will be effective upon Memorial's receipt and processing of my written revocation, however, the revocation will have no effect on any prior disclosures made in reliance of the Authorization.
- I have read and understand the terms of this Authorization. By my signature, I hereby, knowingly and voluntarily authorize Memorial 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.**

Please direct your request to the appropriate department at Memorial:

Medical record requests – Medical Records (618) 257–5300

X-ray requests – Radiology (618) 257–5000

Itemized bill requests – Patient Accounts (618) 257–5523

NOTE: Any alteration or modification of this form will delay processing and provision of the requested protected health information.

**For Department Use Only:**

Driver's License #: \_\_\_\_\_  Other: \_\_\_\_\_

Identification checked by: \_\_\_\_\_ (employee)

**Do Not Write Below This Line**

**AUTHORIZATION FOR DISCLOSURE**