BLESSING Health System

Medical Record Number _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient: _____ *Date of Birth:* _____

Number to call (_____) _____ - _____ Call when ready? (circle) yes no (Circle) Email Fax Mail Pick-up

Date of Request: _____ *Date Needed*: _____ *Number to fax (_____) _____-_____*

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

RECORDS COMING FROM:

☐ Blessing Hospital ☐ Blessing Physician Services

☐ Blessing Walk-In ☐ Illini Community Hospital

c/o Health Information Management

Telephone: 217-223-8400 x 6600 Fax: 217-214-5890

RECORDS GOING TO:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

The type of information to be used or disclosed is as follows *(check all of the appropriate boxes and details as needed)*:

Dates of Service/Treatment (include specific dates or date range): _____

HOSPITAL SETTING

☐ Continuing Care Abstract (includes all Physician dictation & Radiology, Lab and Cardiology reports)

☐ Discharge Summary
☐ History and Physical
☐ Consultations
☐ Operative Reports
☐ Emergency Department Records
☐ Laboratory and Pathology Reports
☐ Cardiology Reports *(EKG, ECHO, Cath, etc)*
☐ X-ray Reports
☐ X-ray Films
☐ Therapy Notes *(PT, ST, OT, Radiation, etc)*
☐ Mental Health Records
☐ Psychological Testing
☐ Clinic Notes *(Wound, Pain)*
☐ Itemized Bill
☐ Entire Record for dates listed

☐ Other *(please specify)*: _____

OFFICE SETTING

☐ Office Notes
☐ Laboratory Reports
☐ Itemized Bill
☐ Immunization Records
☐ Physical Forms
☐ Mental Health Records
☐ Entire Record for dates of service
☐ Workability or School Release forms

☐ Other *(please specify)*: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, genetic testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services even though I am protected by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2, the Illinois AIDS Confidentiality Act, or the Mental Health and Developmental Disabilities Confidentiality Act. A request in writing must be made to exclude the above from the disclosed information.

I understand photo identification may be required to obtain medical records.

The purpose for which this disclosure is being made is:

☐ My personal records
☐ Sharing with other healthcare providers
☐ Other *(please describe)* _____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. In accordance with the Mental Health Code – No person or agency to whom any information is disclosed may re-disclose such information unless the person who consented to the disclosure specifically consents to such re-disclosure. I understand that I have the right to inspect and copy the information that is to be disclosed.

This Authorization expires on: _____. If I fail to specify an expiration date, this authorization will expire six months from date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information. Electronic images/records (ie Radiology) on CD/USB media are not encrypted or password-protected and are the sole responsibility of the recipient of the records to protect from unauthorized viewing. Unencrypted CD/USB media cannot be mailed by Blessing.

_____ _____ _____ _____

Witness *Date* *Signature of Patient or Legal Representative* *Date*

_____ _____ *Legal Representative Relationship (POA)* _____

Minor Age 12 to 17 *Date*

This Authorization must be signed by the patient or guardian if patient is less than 12. In keeping with the Mental Health & Services Disability Confidentiality Act, if the patient is a minor and recipient is 12 years of age or older, then this authorization must be signed by the patient. If the patient is mentally incompetent and over the age of 18, this Authorization must be signed by the appointed legal representative of the patient.

GUIDELINES FOR COMPLETING
"AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION" FORM

Name of Patient:	Legal name of patient.
Medical Records No:	Number assigned to patient (if unknown, leave blank)
Date of Request:	The date information is requested from Blessing or the date that Blessing is requesting information.
Date Needed:	Only to be used as a guide for Blessing Hospital on when a requesting party needs the requested information.
Date of Birth:	Patient's date of birth.
FROM:	Please select which Blessing entity records are being requested from.
TO:	Write name of where records are to be sent. If patient is taking records to someone else, write patient's name.
Date of Service:	Date of records needed, this can be a date range (i.e. "99 to present", or specific lab report on 06/01/01).
Type of Record Requested:	Check the box that applies (i.e. "Mental Health Records").
Purpose:	Check box that applies. "Sharing with other healthcare providers" could be to give or receive information.
Expiration:	Any date can be written here, if left blank, 6 months may apply.