OSF
ST. JOSEPH MEDICAL CENTER

_____
MRN (for office use only)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Must Complete All Blank Lines

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _(_____)_____

City: _____State:_____Zip:_____

1. **I authorize the use or disclosure** of the above named individual's health information as described below:
2. The following organization or individual **is authorized to release the information** or make the disclosure:

OSF SJMC HEALTH INFORMATION SERVICES
2200 E. WASHINGTON ST. **PH: (309) 665-5992**
BLOOMINGTON, IL 61701 **FAX: (309) 662-2103**

3. The **nature of the information** to be used or disclosed is as specified below: (specify date range)

From (Admission Date) _____ to (Discharge Date) _____

and/ or the outpatient period of _____

☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Pathology Reports
☐ Diagnostic Test Results
☐ Progress Notes
☐ Consultation Reports
☐ Rehab Records
☐ Emergency Department Record
☐ Other (Specify) _____

☐ Laboratory Slides
☐ Medical Images
☐ Itemized Statement
(will be sent separately)

HIGHLY CONFIDENTIAL INFORMATION
MUST BE CHECK MARKED & INITIALED TO BE VALID
☐ Mental Health Information _____
☐ Developmental Disabilities Information _____
☐ Sexually Transmitted Diseases _____
☐ Genetic Testing _____
☐ HIV/ AIDS Testing or Treatment _____
☐ Alcohol and/ or Drug Abuse _____
Re-disclosure by recipient(s) is not permitted

4. This information **may be disclosed to or used by** the following individual, class of persons or organization:

_____

Address/ Phone Number: _____

5. **For the purpose(s) of:** _____
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** 1 year from the date of signature on this authorization form.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, which will **prevent disclosure of information**. I understand that the above persons or organization authorized to make the requested disclosure **may not condition treatment** or payment upon completion of this form. I understand I have the **right to inspect or copy** the information to be used or disclosed. 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 privacy laws. If I have questions about disclosure of my health information, I can contact the SJMC privacy officer at (309) 662-3311.

_____ _____
Signature of Patient ***Date***

_____
Signed by Patient Representative, state relationship to Patient and provide evidence of Authority to act for individual

_____ _____
Signature of child (age 12 – 17) for Mental Health and Developmental Disability purposes only ***Date***

_____
Signature of witness who can verify patient identity