

Dr. John Warner Hospital
422 W. White
Clinton, Illinois 61727
217-935-9571

Rural Health Center
422 W. White
Clinton, Illinois 61727
217-937-5284 Fax 217-937-5293

AUTHORIZATION
TO USE AND DISCLOSE HEALTH INFORMATION
FOR PURPOSES OTHER THAN TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient's Name: _____
Address: _____

Date of Birth: _____
SSN#: _____
Phone #: _____

I authorize the Dr. John Warner Hospital Rural Health Center Other _____
to disclose the protected health information contained in my medical records as directed below:

1. The name and address of the person(s), the class of person or the organization(s) to whom disclosure is to be made and by whom use can be made of my protected health information:

2. Approximate dates of treatment: _____

Specific description of health information to be released:

- | | | |
|---|---|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Alcohol & Drug Abuse |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> HIV Tests Results & Related Information |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> MD Progress Notes | <input type="checkbox"/> Psychiatric (only if this box is checked will psychiatric records be released) |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Lab, X-Ray Pathology Reports | |
| <input type="checkbox"/> X-ray films | <input type="checkbox"/> Other _____ | |

3. The purpose for disclosing and/or using the protected health information:

(at the request of the individual; further care; transfer of care; insurance claim; attorney inquiry, etc.)

4. Unless revoked by me sooner, this authorization shall be effective for ninety (90) days after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below.

5. I understand and acknowledge that the protected health information disclosed and/or used pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by law.

6. I understand and acknowledge that I may revoke this authorization in writing at any time by directing the written revocation to the Dr. John Warner Hospital, Medical Records Department or Rural Health Center, Clinton, Illinois. I further understand and acknowledge that my revocation may not be effective to the extent that 1) the Dr. John Warner Hospital or Rural Health Center has already taken action in reliance upon the authorization or 2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. I understand and acknowledge that the Dr. John Warner Hospital or Rural Health Center may not condition my treatment on whether I sign this authorization, except when the treatment is performed for a third party (such as an employer or insurance carrier) and the protected health information is to be disclosed directly to that third party. In that case my failure to sign this authorization may result in the denial of or other restriction on such treatment.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

Signature of Patient or Legally Authorized Representative

Date

If not Patient, then Relationship of Legally Authorized Representative to Patient

ID Verified By: Driver's License # _____ Known to Me Other

Released by

Date