Perry Memorial Hospital

530 Park Avenue East • Princeton, Illinois • 815/875-2811

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____ hereby authorize _____
(Name of patient or Authorized Agent)

to release to: _____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
(Street Address, City, State and Zip Code)

The following information contained in the patient record of _____
(Patient's Name)

born _____ residing at _____
(Birthdate) (Street Address, City, State and Zip Code)

☐ Complete chart, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records, unless otherwise noted below.

☐ Pertinent documents only to include: Physician dictation/notes/orders; Clinical Reports; excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records, unless otherwise noted below.

☐ Mental Health Treatment Records

☐ Alcoholism Treatment Records

☐ Drug Abuse Treatment Records

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

☐ Laboratory/Pathology Reports ☐ Specimen Blocks/Slides

☐ Radiology Reports ☐ Radiology Films/Studies

☐ Other: _____

The above information for the following period of time shall be released: From _____ (Date) to _____ (Date)

The purpose of the authorization is _____

_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
I understand that this facility may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to this facility of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where this facility has already relied on it to use or disclose my health information. Written revocation must be sent to the facility. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____
(Date)

Signed: _____ Date: _____
(Patient/Personal Representative)

If you are the personal representative, please specify your relationship to the patient: _____