MASON DISTRICT HOSPITAL
615 N. PROMENADE
P.O. BOX 530
HAVANA, IL 62644
309/543-8580
Fax: 309/543-8514

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This entire authorization must be filled out completely. If all areas are not filled out completely and accurately, the authorization will be returned to you requesting the additional needed information.

1. I hereby authorize ________________________ (name of provider) to disclose the following information from the health records of:

Patient Name _____________________ Date of Birth ________________________

Address _________________________ Telephone __________________________

_________________________

covering the period(s) of healthcare from __/__/__ to __/__/__

2. Information to be disclosed:

[ ] History & Physical
[ ] Discharge Summary
[ ] Operative Report
[ ] Entire Record
[ ] Laboratory Results
[ ] X-Ray Reports
[ ] EKG
[ ] Other (specify) _________________

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and treatment for alcohol and drug abuse. If contained in the health record this information may be disclosed unless indicated hereby initialing on this line ____ and checking the information not to be disclosed. Do not release the following information (check those that apply):

[ ] AIDS or HIV Info
[ ] Sexually Transmitted Disease
[ ] Behavioral or Mental Services
[ ] Drug/Alcohol Abuse

4. This information may be disclosed to __________________________________________ for the purpose of _________________________________________________________.

**-OVER-**

5. I understand this authorization may be revoked in writing at any time and submitted to the Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that 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.

6. I understand this authorization will expire, without my express revocation, ninety (90) days from the date of signing, or if I am a minor, on the date I become an adult according to state law.

7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

By signing I acknowledge that I have read, understand and agree with the above. By signing I further understand that I may be charged in accordance with state and federal statutes for the processing of the requested records.

_______________________________________________ ________________________
Signature of patient or legal representative Date

If signed by legal representative, relationship to
patient _________________________________________

_______________________________________________ ________________________
Signature of witness Date

**You are entitled to a copy of this authorization after you sign it.**