

Patient Name (Print): _____ Date of Birth: _____

Address: _____

Telephone Number _____ Social Security Number (Last 4 digits) XXX-XX-_____

I, _____, do hereby authorize

Graham Hospital

Graham Medical Group

Other: _____
(Hospital/Physician/Nursing Home/Clinic name and address)

to release the following individually identifiable health information (check all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Final Summary | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Emergency Record | <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> EKG and/or EEG | <input type="checkbox"/> Doctors Orders | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Complete File |
| <input type="checkbox"/> Other (specify): _____ | | | |

REGARDING DATES OF SERVICE: from _____ to _____ are authorized for release.
(Admit Date) (Discharge Date)

Under Illinois law, you must separately and expressly authorize the release of any of the following **Highly Confidential** information. By placing my **INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed.

_____ HIV/AIDS related information	_____ Venereal Diseases	_____ Sexual Assault
_____ Mental Health Information	_____ Child Abuse/Neglect	_____ Genetic Testing
_____ Substance Abuse (Drug/Alcohol)	_____ Abuse of an adult with a disability	

RELEASE RECORDS TO: (Name & address to disclose or send records)

PURPOSE OF DISCLOSURE:

- Transfer of Care Insurance Legal Consultation Consultation with Physician
 Treatment Plan/Coordination or care Other (specify): _____

METHOD OF DISCLOSURE: Paper Copy or Password Protected CD

 **GRAHAM HEALTH SYSTEM**
210 W. WALNUT ST.
CANTON, IL 61520
(309) 647-5240

**AUTHORIZATION FOR
DISCLOSURE OF CONFIDENTIAL
HEALTH INFORMATION**



TERM: This Authorization request does not apply to any treatment dates beyond the date of signature. It will remain in effect for no more than one year. If a lesser term is needed, please indicate:

until Graham fulfills 90 days from the date of authorization other(specify) _____

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 Graham Health System may not condition treatment based on my unwillingness to sign this release.

I understand that I may revoke this authorization by providing written notice to the Graham Health System Health Information Department. I understand that if I revoke this authorization, it will not apply to information that has already been released in response to this authorization.

I understand any information disclosed may be subject to re-disclosure by the receiving person(s) or organizations and no longer protected by the federal privacy regulations.

I understand that I have a right to inspect or copy the information to be used or disclosed.

I understand standard copying fees per Illinois 735 ilcs 5/8-2006 may apply.

I understand that if I sign this authorization, I will be provided a copy of this authorization.

By signing below I agree to the statements in this authorization form.

NOTICE TO RECEIVING AGENCY/PERSON: Re-disclosure Prohibited: Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of this information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by written consent of the patient.

*Signature of Patient**

Date

Signature of Parent/Legal Guardian/Legal Representative

Date

Relationship to the Patient

*Witness Signature***

Date

*Minors 12 years of age or older shall sign for release of their records pertaining to STDs, substance abuse, mental health and developmental diseases.

**Witness' Signature is required for release of information regarding mental illness or developmental disability.

GRAHAM HOSPITAL
210 W. Walnut
Canton, IL 61520
(309) 647-5240

GRAHAM MEDICAL GROUP
180 S. Main
Canton, IL 61520
(309) 647-0201



GRAHAM HEALTH SYSTEM
210 W. WALNUT ST.
CANTON, IL 61520
(309) 647-5240

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