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):

❑ Face Sheet	❑ Operative Report	❑ Immunization Record	❑ Physical
❑ Final Summary	❑ Pathology Report	❑ Progress Notes	❑ Lab Reports
❑ Emergency Record	❑ History & Physical	❑ X−Ray Reports	❑ Consultations
❑ EKG and/or EEG	❑ Doctors Orders	❑ Office Visit	❑ Complete File

❑ 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

ROCI

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

Rev. 03/2017

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