Ferrell Hospital
DEACONESS ILLINOIS PARTNER

Account #_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I,_____ hereby authorize _____to
(Person Signing Authorization) (Healthcare Provider/Medical Facility)

furnish the following medical information to _____
(Name of Receiving Party)

Purpose of disclosure: ☐ Continuation of care ☐ Personal use ☐ Other:_____

Patient's Name:_____Date of Birth:_____

Address:_____

Date(s) of Service:_____

Specific information to be released:

☐	Discharge Summary	☐	Pathology Report	☐	Progress Notes/Clinic Visits
☐	History and Physical	☐	Laboratory Reports	☐	Mammogram Reports
☐	Emergency Room Report	☐	Radiology Reports	☐	Operative Report
☐	Consultation Report	☐	Respiratory Reports	☐	Other _____

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify and expiration date, event or condition, this authorization will **expire in 6 months**.

I understand that the information that is being disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected under the Health Insurance Portability Accountability Act.

I agree that a photocopy of this authorization is as valid as the original.

Signed:X_____Date:X_____
(Patient/Representative)

Witness:_____Date released:_____
(Hospital Employee/Witness)

ID Provided_____

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