HARDIN COUNTY GENERAL HOSPITAL/CLINIC
PO BOX 2467, FERRELL ROAD
ROSICLARE, IL 62982
Phone: 618-285-6634/Fax: 618-285-2885
www.ilhcgh.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____ _____
Patient Name Date of Birth MR#

I hereby authorize _____ to release the following health
Releasing Provider
information to _____.
Name of receiving provider/Individual

Purpose of Disclosure: ☐ Continuation of Care ☐ Personal Use ☐ Other

Dates of Service: _____ to _____

Specific Information to be Released:

☐ Discharge Summary	☐ History and Physical	☐ Progress Note(s)
☐ ER Record	☐ Laboratory	☐ Radiology
☐ Operative Record	☐ Itemized Statement	☐ Other _____

I understand that this information may include information related to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), Sickle Cell Anemia or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand that I have a right to revoke this authorization at any time, that if I choose to 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. 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. Unless otherwise revoked, this authorization will expire 90 days from the date signed.

I further understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164-534. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my PHI, I can contact the Health Information Department.

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the PHI under the above stated terms.

_____
Signature of Patient/Legal Representative Date and time signed

_____
Relationship to patient Signature of Witness