AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

FAIRFIELD MEMORIAL HOSPITAL
303 NW 11TH STREET
FAIRFIELD, IL 62837
PHONE: 618-847-8247; FAX: 618-847-8379

Patient's Name: _____ DOB: _____ MR #: _____

Address: _____

Information to be released:			
☐ Discharge summary	☐ History/Physical	☐ Consultation report	☐ Lab results
☐ Operative Report	☐ Radiology reports/film	☐ Pathology report	☐ EKGs
☐ Clinical Notes	☐ ER	☐ PT	☐ Other:
Treatment Dates: from_____ to _____			

Information to be disclosed will be used for: Check the appropriate box(es) and include other info where indicated:			
☐ Continuity of care	☐ Insurance	☐ Litigation	☐ Personal
☐ Physician	☐ Other		

☐ Release **TO** Fairfield Memorial Hospital** Attn:		☐ Release **FROM** Fairfield Memorial Hospital Attn:
Name:		
Facility:		
Address:		
City:	State:	Zip Code:
Phone:	Fax (if known):	

If releasing information **TO Fairfield Memorial Hospital, please return a copy of this form with the materials requested**

- I understand that any information disclosed may include information related to sexually transmitted disease, Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus. It may also include information about behavioral mental health services and treatment for alcohol and drug abuse.
- I understand that I may revoke this authorization at any time by WRITTEN REQUEST.
- I understand that the revocation will not apply to information already released in response to this authorization.
- A photocopy or facsimile of this authorization will be treated in the same manner as the original, and the healthcare organization may deny release of PHI, if (1) is not a true and accurate authorization initiated by the patient or (2) is dated prior to the treatment dates for which records are being requested.
- I understand that once information is released pursuant to this authorization, Fairfield Memorial Hospital cannot prevent the re-disclosure of the information to a third party.
- I understand that PHI may be used and disclosed to carry out treatment, payment, or healthcare operations.
- I understand I have the right to request that FMH restrict how PHI is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that is certain circumstances FMH has the right to deny requested restrictions. However, if FMH agrees to a requested restriction it is binding.
- I understand that there may be a charge associated with the Release of Information services rendered. There is no charge for release of information to other health care facilities.

This signed consent form will be kept for a period of six (6) years by FMH. For more information regarding your Privacy rights and responsibilities please refer to the FMH HIPAA Privacy Notice. This authorization will expire ONE YEAR following the date of signature except in the case of continuing care and is not applicable to future dates of treatment once signed and dated.

_____ _____ _____ _____

Patient/Parent/Legal Responsible Party | Relationship | Date | Time

Identification is required

FOR FMH COMPLETION BELOW

Date Received: _____ Date Processed: _____ Request Completed by: _____

Logged? _____ Date: _____ by _____

MR-2 (5-14)