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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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

Address: _____

I AUTHORIZE FAIRFIELD MEMORIAL HOSPITAL/HORIZON HEALTHCARE TO USE OR DISCLOSE MY HIPAA PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW.

Information to be released:					
☐ Discharge summary	☐ History/Physical	☐ Consultation report	☐ Lab results	☐ EKGs	☐ Entire Records
☐ Operative Report	☐ Radiology reports/film	☐ Pathology report	☐ Pain Center Notes	☐ Wound Care Notes	☐ Problem List
☐ Clinical Notes	☐ ER	☐ PT	☐ Other:		☐ Immunization Record
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**

- 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 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.

PLEASE INITIAL EACH ITEM BELOW TO INDICATE YOUR UNDERSTANDING

_____ I understand the information in my health record may include information relation to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency diseases (HIV). It may also contain information concerning behavioral or mental health services, and the treatment of alcohol or drug abuse.

_____ I understand once the information above is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand that if I choose to revoke this authorization that I need to do so in writing, and also present it to Fairfield Memorial Hospital. I understand that a revocation does not apply to an insurance company when the law provides the insurer with the right to contest a claim under policy.

_____ I understand authorizing the use or release of this information is voluntary. I do not have to sign this form to ensure healthcare treatment.

_____ _____ _____ _____

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 (8-17)