Patient Authorization to Disclose Protected Health Information

Patient's Name: _____ DOB: _____

The undersigned hereby authorizes disclosure of protected health information

FROM:	**TO:**
_____ Individual or Institution	_____ Individual or Institution
_____ Street Address	_____ Street Address
_____ City/State/Zip	_____ City/State/Zip
_____ Phone/Fax #	_____ Phone/Fax #

The purpose or need for the information is: _____

***As to mental health or developmental disability information, only information relevant to the purpose for which disclosure is sought may be disclosed.**

Information to be disclosed as indicated below:

___Complete medical record
from (date) _____ to (date) _____ **OR** _____ ALL Dates

___ Diagnostic testing; Type of test _____ Date of test _____

_____ Date of test _____

___ Immunization records: ____ Adult ____ Pediatric

___ Physician office examination notes
from (date) _____ to (date) _____ **OR** _____ ALL Dates

___ Other / **Must specify:** _____

**** Section not applicable for disclosures to patient for personal use****

READ THIS SECTION CAREFULLY – Disclosures Requiring Special Authorization

By **marking** any of the information below, I specifically authorize the use or disclosure of information containing these categories of highly confidential information:

___ Mental Health or Development Disabilities ___ Substance Abuse (Drug/Alcohol)

___ HIV/AIDS Testing or Treatment ___ Sexually Transmitted Diseases

This authorization will expire 180 days from the date of signature unless a date or event prior to 180 days is specified: _____

(enter the date or event that you request this authorization to expire if less than 180 days)

Complete Both Sides of Form

Patient Authorization to Disclose Protected Health Information

My signature below acknowledges that I understand that:

- Illinois and federal laws prohibit third parties from redisclosing mental health, developmental disability, and substance abuse treatment information. For other information, I understand that once Memorial Medical Group, LLC discloses my health information to the recipient, MMG cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.
- If I refuse to authorize disclosure of this information, the following are consequences (specify if any)

  _____
- I may refuse to sign or, at any time, may revoke this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment provided by MMG providers; except, however, if my treatment by MMG providers is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, MMG providers may refuse to treat me if I do not sign this Authorization.
- I have the right to inspect or obtain a copy of the information being disclosed.
- This Authorization will remain in effect until the term of this Authorization specified herein expires or I provide a written notice of revocation for this Authorization. The revocation will be effective upon MMG's receipt and processing, however, the revocation will have no effect on any prior disclosures made in reliance of the Authorization.
- The physician may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with the annual adjustment of copying fees as established with the state of Illinois in accordance with 73 ILCS 5/8-2001.
- I have read and understand the terms of this Authorization. By my signature, I hearby, knowingly and voluntarily authorize Memorial Medical Group, LLC (MMG) to use or disclose my health information in the manner described above.

_____ _____ _____

(Patient Signature) (Date) * (Witness Signature)

If the patient is a minor or is otherwise unable to sign, the patient's Personal Representative must sign.

_____ _____ _____

Authorized Personal Representative Date Relationship to Patient

_____ _____

*Witness Date

***Witness signature required for release of Mental Health or Developmental Disability Information.**

The following section must be completed if someone other than the patient is authorizing disclosure.

_____ _____ _____

(Signature of authorized personal representative) (Date) (Relationship to patient)

_____ _____

(Witness signature) (Date)

_____

To be completed by the Office Staff:

Print Name of Authorized Representative _____

**Valid Driver's License / ID # _____ Exp date:_____

Identification verified by: _____(Employee) ** **Attach copy of Drivers License/ID**

Complete Both Sides of Form