Hillsboro Area Hospital
1200 E. Tremont St. Hillsboro, IL 62049 217-532-6111

Patient Name_____Date of Birth_____
Patient Address_____City, State_____
Admission Date_____Type of Service_____

Authorization For The Release of Health Information

I hereby authorize Hillsboro Area Hospital ("the facility") to disclose my individually identifiable health information as described below.

Name and Address of person(s) or organization(s) Requesting records, if different than patient:

_____
_____
_____
_____

Name and Address of person(s) or organization(s) to receive the records:

_____
_____
_____
_____

☐ I wish to have the following records copied and and I will pick them up at the facility.

☐I am requesting that the facility copy the following and send the records to the above address.

☐I wish to have the following records electronically

INFORMATION REQUESTED

I am requesting the following records from the patient's medical record that were created between _____ and _____

☐Admission Form
☐X-ray Reports
☐X-ray Films
☐Progress Notes-Physician
☐Progress Notes-Nurses
☐Discharge Summary
☐History & Physical Examination
☐Operative Reports
☐Laboratory Reports
☐Emergency Room Records
☐Pathology Reports
☐Physical Therapy
☐Care Plans
☐Other (must specify) _____

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.

Purpose of disclosure: ☐Request of individual ☐Healthcare treatment/services ☐Other _____

Legal Authority for Request:

☐ I am the patient noted above.
☐ I am the parent of the minor patient noted above.
☐ I am the patient's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical records. If a DPAHC is attached, then I also have included evidence that the patient's attending physician has determined that the patient has lost the capacity to make informed health care decisions.
☐ I am the patient's legal guardian, and have attached to this authorization a valid appointment of guardianship from a probate court.

☐ The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.
☐ The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the patient's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a power of attorney or probate court order.

Understanding & Agreements of Requestor:

1. This authorization is voluntary.
2. This authorization will expire _____
(enter "N/A" if never until revoked in writing, or enter a date or event, such as "60 days from the date of my signature below", etc). If blank, "N/A" is assumed.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do so, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility related to the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
6. If I am the patient, I understand that the facility may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
7. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time, but no later than sixty (60) days from the facility's receipt of my request.
8. I understand that if I wish to have copies of records made, the facility may assess a handling fee and per page fee for copying the records according to the rates set forth by the State of IL Comptroller's Office, plus actual shipping costs.
9. If applicable, the facility will notify me of the total amount due for copying and handling of the requested records. I agree that the facility will only send the requested information once it has received payment in full for those costs.

Signature of Person Making Request_____Date_____

Printed Name of Person Making Request_____

TO BE COMPLETED BY HOSPITAL:

☐ Photo Identification Verified ☐Signature Verification