HILLSBORO health

Hillsboro Health Patient Authorization for Disclosure of Health Information:

Patient Name :_____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from Hillsboro Health be disclosed to:

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: _____

Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s): ☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Immunization Record ☐ Complete Medical Record (all pages) ☐ Radiology film/ imaging studies/tracing/media ☐ Pathology Slides ☐ Itemized Billing Records ☐ Abstract/ Summary (Includes Discharge Summary, History and Physical, Operative Report(s), Consultations and Test Results)

☐ Test Result (s) of: _____

☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health Records	☐ Yes	☐ No	Dates: _____
Psychotherapy Records	☐ Yes	☐ No	Dates: _____
Genetic Records	☐ Yes	☐ No	Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR**
☐ All past, present, and future encounters/visits

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

Disclosure Format (Paper is default if not marked.): ☐ US Mail ☐ Fax _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 1200 E. Tremont St., Hillsboro, IL 62049. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Completed form may be returned in the following ways:
-Mailed to - ATTN: Medical Records, Hillsboro Health, 1200 E. Tremont St., Hillsboro, IL 62049 ,
-Hand delivered to the front desk of Hillsboro Health,
-Faxed to ATTN: Medical Records at 217.532.2726.

(For Office Use Only)
Account Number: ***Medical Record Number:***