McDonough District Hospital

525 East Grant Street, Macomb, IL 61455
(309) 833-4101
www.mdh.org

REV: 12.21.18 nld **MR-264** 9565408 EFF: 12.21.18

Authorization for Use or Disclosure of Protected Health Information

I authorize McDonough District Hospital and/or it's administrative and clinical staff to use ______ disclose _____ Protected Health Information concerning

(Name of Patient)____ (Date of Birth)_________________

(Address) _______________________________ (Phone #) ____________ (Email Address) ________________

from:

(Requested from)____

____

to:

(Recipient)____

____

This Protected Health Information is being used or disclosed for the following purposes:

____

____

I authorize the use or release of the following:

Psychiatric Information	Yes ___	No ___
Chemical Dependency Information	Yes ___	No ___
STD / AIDS / HIV Information	Yes ___	No ___
Abuse / Neglect	Yes ___	No ___
Genetic Testing	Yes ___	No ___

The following information is to be released:

___ Biopsychosocial Assessment	___ Laboratory Results	___ Rehab Records (PT/OT)
___ Diagnosis	___ Progress Notes	___ Operative Reports
___ Discharge Summary	___ Psychiatric Evaluation	___ Consultations
___ Face Sheet	___ Treatment Plan	
___ Immunization / Allergy Note	___ X-rays	

___ Letter to: ____

___ Information needed to complete form for: ____

I authorize the release of the following other information: ____

____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the MDH Privacy Officer at 525 East Grant Street, Macomb, Illinois 61455. I understand that a revocation is not effective to the extent that MDH has relied on the use or disclosure of the Protected Health Information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

MDH will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

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I understand that I have the right to read and/or receive a copy of the information being disclosed, for the required fee. A photocopy or facsimile (fax) of this consent shall be as valid as the original.

The following is applicable to information released under the Illinois Mental Health and Developmental Disabilities Confidentiality Act:

I understand that this authorization will automatically expire on the date specified.

This authorization is valid until: ________________

The consequences of refusing to sign this form are:

- information will not be released.

I understand release of information can take up to thirty (30) days.

_________________________________ _________________________________
Signature of Patient or Personal Representative Witness

_________________________________ _________________________________
Date Date

____
Print Name of Patient or Personal Representative

____
Description of Personal Representative's Authority to Act

Acknowledgment of receipt of a copy of this Authorization

_________________________________ ________________
Signature of Patient or Personal Representative Date

NOTICE TO RECEIVING AGENCY/PERSON: Under the provision of the IL Mental Health & Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents of such redisclosure. This information is disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by 42 CFR 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Office Use ONLY

I have authenticated the identity of the person named on this authorization form:

☐ **Picture ID** ☐ **Person Known to Me** ☐ **Other (specify)** ________________________

Employee Signature: ____ **Date:** ______________