



SOUTHERN ILLINOIS HEALTHCARE

- Herrin Hospital, St. Joseph Memorial Hospital, Memorial Hospital of Carbondale, Ferrell Hospital, Miners Memorial Health Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ hereby authorize _____ to _____
(Person Signing Authorization) (Healthcare Provider)

furnish the following medical information to _____

(Name and Address of Receiving Party)

Purpose of disclosure: [] Request of individual [] Other _____

Patient Name: _____ Date of Birth: _____

Specific Information to be Released: _____ Date of Treatment: _____

- [] Discharge Summary [] Pathology Report [] Itemized Bills
[] History and Physical [] Laboratory Reports
[] Emergency Room Report [] Radiology Reports
[] Operative Report [] Other _____

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.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months, or _____ (date).

I understand that the information (excluding mental health information) that is being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree that a photocopy of this authorization is as valid as the original.

Signed: _____ Date: _____
(Patient / Legal Representative)

If signed by other than the patient, please indicate relationship and why patient did not sign: _____

Witness: _____ Date: _____
(Hospital Employee)

Instructions For Obtaining Copies Of Protected Health Information (Medical Records)

To facilitate your request for copies of medical records please follow the instructions below

1) Complete all sections, making to sure to:

- identify healthcare facility name
- name and address to whom the copies are to be sent
- reason copies are being requested
- Dates (approximate if not known) of treatment/service of PHI (medical records) requested to be copied
- Signature* and date

2) Mail the completed form to:

Health Information Department
Southern Illinois Healthcare
System Office
1239 E Main
Carbondale, IL 62901

3) Fees for copies. There is no charge for copies of medical records requested for patient care related purposes, such as to send to a physician, healthcare provider or healthcare entity.

If you are requesting copies for personal reasons, the first 5 pages copied are provided at no charge. For copies of 6 or more pages please refer to the below pricing structure:

- o .85 per page 6-25 pages copied
- o .55 per page 26-50 pages copies
- o .25 per page 51 pages or more
- o 1.40 per page if medical records have been transferred to microfilm storage.

To minimize the cost, it is suggested to limit your request to the following medical record documents:

- Emergency Room Record
- Discharge Summary
- History and Physical
- Operative Report
- Pathology Report
- Diagnostic tests results (Labs, X-ray, EKG, etc)

*Guidelines for Signature

- To assure patient privacy, the Authorization form must be signed by the patient.
- If the patient, is deceased, please provide a death certificate and copy of Letters of Office. I no Letters of Office, please provide copy of deceased patient's will or Small Estate Affidavit..
- If the patient is incapacitated, please provide a copy of the Power of Attorney for Healthcare or proof of Letters of Office of Guardianship.
- If the patient is a minor (under the age of 18) the authorization must be signed by the parent.
- If the patient is an emancipated minor or a pregnant minor the authorization can be signed by the minor patient.
- If the request involves medical records pertaining to mental health, drug and alcohol and/or AIDS/HIV, please contact the Health Information Department at the respective SIH hospital for further instructions.