

Fairfield Memorial Hospital

303 NW 11th Street

Fairfield, IL. 62837

Phone: 618-847-8247; Fax: 618-847-8379

**AUTHORIZATION FOR RELEASE OF
PROTECTED PATIENT HEALTH INFORMATION**

Patient's Name _____ D.O.B. _____ MR# _____

Address _____

Information to be released:

- | | | |
|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History/Physical | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Lab results | <input type="checkbox"/> Radiology reports/film | <input type="checkbox"/> EKGs |
| <input type="checkbox"/> Operative report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Clinical Notes |
| <input type="checkbox"/> ER | <input type="checkbox"/> PT | |
| <input type="checkbox"/> Other _____ | | |

Treatment Dates: from _____ to _____

Information to be disclosed will be used for; Check the appropriate box (ex) and include other info where indicates

- | | | | |
|---|--------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Litigation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Other _____ | | |

Release TO Fairfield Memorial Hospital

ATTN: _____

Release FROM Fairfield Memorial Hospital

ATTN: _____

Name: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone: _____ FAX (If known) _____

****If release information TO Fairfield Memorial Hospital, please return a copy of this form with the materials requested****

- I understand that any information disclosed may include information related to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome, or Human Immunodeficiency Virus. It may also include information about behavioral mental health services and treatment for alcohol and drug abuse.
- I understand that I may revoke this authorization at any time by WRITTEN REQUEST
- I understand that the revocation will not apply to information already released in response to this authorization
- A photocopy or facsimile of this authorization will be treated in the same manner as the original, and the healthcare organization may deny release of protected health information, if 1) is not a true and accurate authorization initiated by the patient or 2) is dated prior to the treatment dates for which records are being requested.
- I understand that once information is released pursuant to this authorization, Fairfield Memorial Hospital cannot prevent the redisclosure of the information to a third party
- **I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.**

This Authorization will expire ONE YEAR following the date of signature except in the case of continuing care and is not applicable to future dates of treatment once signed and dated.

Patient/Parent/Legal Responsible Party

Relationship

Date

Identification will be required

-----**FOR FMH COMPLETION BELOW**-----

Date Received _____ Date Processed _____ Request Completed by _____

Logged ? _____ Date _____ by _____