FAIRFIELD MEMORIAL HOSPITAL
DEACONESS ILLINOIS PARTNER

FAIRFIELD MEMORIAL HOSPITAL AND HORIZON HEALTHCARE
HEALTH INFORMATION DEPARTMENT
303 NW 11th Street
Fairfield IL 62837
PHONE# 618-847-8247 FAX# 618-847-8379

HORIZON HEALTHCARE
Caring Through A Lifetime.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE # _____

NEXT APPOINTMENT DATE _____ PROVIDER _____

I AUTHORIZE FAIRFIELD MEMORIAL HOSPITAL / HORIZON HEALTHCARE TO USE OF DISCLOSE MY HIPAA PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

OBTAIN RECORDS FROM:

NAME OF FACILITY _____
ADDRESS _____
_____
PHONE _____
FAX _____

RELEASE RECORDS TO:

NAME OF FACILITY _____
ADDRESS _____
_____
PHONE _____
FAX _____

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

Information to be released / disclosed:

___Lab / Pathology Report ___Clinic Visit Notes ___ER Record ___Cardio/Pulmonary Reports

___Radiology Reports ___Digital Images ___Therapy Notes ___Immunization Record

___Abstract/Summary Reports (Admisssion/Discharge, Operative Reports)

___Other _____

Specific Dates: _____ to: _____

*For Vertex Shared Imaging **ONLY** provide e-mail address below:*

_____

Information will be used for: ___Legal ___Personal ___Insurance ___Continuity of Care ___Transfer of Care ___Other _____

- 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 PHI, 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 PHI may be used and disclosed to carry out treatment, payment, or healthcare operations.
- I understand I have the right to request that FMH restrict how PHI is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that is certain circumstances FMH has the right to deny requested restrictions. However, if FMH agrees to a requested restriction it is binding.
- I understand records will released as quickly as possible and in the format I request (or an acceptable alternative). There may be a charge for large volume requests or requests from certain third party organizations. There is no charge for release of information to other health care facilities.

This signed consent form will be kept for a period of ten (10) years by FMH. For more information regarding your Privacy rights and responsibilities please refer to the FMH HIPAA Privacy Notice. This authorization will expire 90 days after the date of signature except in the case of continuing care and is not applicable to future dates of treatment once signed and dated.

PLEASE INITIAL EACH ITEM BELOW TO INDICATE YOUR UNDERSTANDING

_____ I understand the information in my health record may include information relation to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency diseases (HIV). It may also contain information concerning behavioral or mental health services, and the treatment of alcohol or drug abuse.

_____ I understand once the information above is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand that if I choose to revoke this authorization that I need to do so in writing, and also present it to Fairfield Memorial Hospital. I understand that a revocation does not apply to an insurance company when the law provides the insurer with the right to contest a claim under policy.

_____ I understand authorizing the use or release of this information is voluntary. I do not have to sign this form to ensure healthcare treatment.

Signature of Patient _____ Date _____ Date consent expires _____

***Children ages 12-17 are required to sign and date consent with parent / legal guardian when requesting records related to mental health service, family planning, substance abuse, or sexually transmitted diseases.*

Signature of Parent or Legal Guardian _____ Date _____ Date consent expires _____

Witness Signature _____ Relationship to Patient _____

Hospital Employee Completing this Form _____ Date of Completion _____ Date Logged in EHR _____