

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Home Telephone No.: _____

Other: _____

- 1. I authorize the use or disclosure of the above named individual's health information as described below.
- 2. The following individual or organization is authorized to make the disclosure: Condell Health Network

OR _____

- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

Name of Report	Date of Service
<input type="checkbox"/> Abstract (Physician Reports, Test results, X-rays and Imaging Reports)	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Laboratory Results	_____
<input type="checkbox"/> X - Rays and Imaging Report	_____
<input type="checkbox"/> Physical Therapy	_____
<input type="checkbox"/> Films	_____
<input type="checkbox"/> Entire Record	_____

- 4. I understand that the information in my health record include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

- 5. The information may be disclosed to and used by the following individual or organization:

Address: _____

for the purpose of _____

- 6. 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 management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.
- 7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Condell Medical Center at (847) 990-5250 or the Privacy Office at (847) 990-5256.

Signature of Patient or Legal Representative _____
Date

If Signed by Legal Representative, Relationship to Patient _____
Signature of Witness

I understand that if this authorization is for the purposes of third party payment to Condell Medical Center that diagnostic and therapeutic information as may be necessary to process benefits will be disclosed to my insurance company and/or the insurance company's review agency, and that refusal to authorize information for this purpose will result in the assignment of financial responsibility to me for these services. No other adverse consequences to me will result if I refuse to sign this authorization. I agree to release and hold harmless Condell Medical Center, its directors, officers, employees, successors, agents, assigns, and any and all members of its medical staff, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure of records/information as authorized herein.



For Healthcare Organization Use Only

Date Received: _____ Health Record No.: _____

Date Sent: _____ Staff member processing request: _____