Shawnee Health Care

AUTHORIZATION FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION

Locations:

- *Marion Wellness*
- *Shawnee Health Care* in Carbondale
- *Shawnee Health Care* in Carterville
- *Shawnee Health Care* in Marion
- *Shawnee Health Care* in Murphysboro
- *Shawnee Health Care, OB/GYN* in Carbondale
- *Shawnee Health Care, OB/GYN* in Herrin
- *Terrier Care*

Shawnee Health Service
c/o Health Information
1335 Cedar Court
Carbondale, IL 62901
Fax: 618-985-9363
E-mail: shshealthinfo@shsdc.org

Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

◆ **REQUIRED INFORMATION**

◆ **Print patient's legal name** _____

◆ **Birthdate** ____/_____/_____ **Previous names** _____ **Phone number**_____

Date(s) of Service Requested:_____

Type of documents Requested: *(e.g. Office Notes)* _____

_____

I recognize that the following information is protected from release by federal or state law without specific authorization. I specifically consent to the disclosure as indicated below**: (please initial next to each type of records that you wish to include in this request.)**

__ AIDS __ Counseling Notes ___ Substance/Alcohol Abuse Notes
__ HIV/STD's testing/results __ Psychotherapy Records ___ Genetic Records ____ Mental Health Records

Choose Disclosure Format (Paper is default if not marked.)

Paper_____ or Electronic (CD) ____

Choose Your Obtain Method : (Mailing to address on file is default)

_____ US Mail to _____

_____ Fax to _____

_____ Email to _____

_____ Pick up by _____ on or before _____ (mm/dd/yyyy)

I understand the following

- Once the records are released, the clinic releasing records cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law.
- I understand this authorization expires on _____, if date is not indicated authorization expires **6 months** from signature date. Authorization can also be revoked at any time by contacting Shawnee Health Service Health Information.
- Shawnee Health Service is not responsible for potential breach of information if unsecure email address is provided by patient.

_____ _____ _____ _____

Date (Signature of Client or Personal Representative) Date (Signature of Parent, Guardian, or witness if required)

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐Other: _____

Notice to Whomever Disclosure is made: This information has been disclosed to you from records whose protected health information is protected by State and Federal Law including 42 CFR Part 2. These laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains.

For Office use only: Received_____ **Completed by**_____ **Date Completed** _____

Verification type: Photo ID _____ **Signature Match:** _____