Shawnee Health Care
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Locations:

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

Shawnee Health Service
c/o Health Information
109 California Street
PO Box 577
Carterville, IL 62918
Fax: 618-985-9363

REQUIRED INFORMATION

Print patient's legal name _____

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

TO/FOR: □ Send Information to □ Obtain Information from □ Other: _____

Name/Organization:_____

Address:_____

Phone Number:_____ Fax Number (Healthcare Provider Only): _____

Reason for Release:
□ Continuation of Care □Transfer of Care □ Personal Record □ Legal Use □ Other _____

Date(s) of Service: _____*(if blank minimum medical records necessary will be disclosed)*
Records that I authorize the use or disclosure of: □ **All pertinent records** or check all that may apply below
□ Visit/Progress Notes □ Radiological Reports □ Problem List □ Immunization Record/Physical
□ Case Management Notes □ Medication List □ Lab Reports □ Dental Records

OTHER:_____

I recognize that the following information is protected from release by federal or state law without specific authorization. I specifically consent to the use or disclosure as indicated below: (**please initial next to each type of records**)
__ AIDS __ Counseling Notes ___ Substance/Alcohol Abuse Notes
__ HIV/STD's testing/results __ Psychotherapy Records ___ Genetic Records ____ Mental Health Records

Disclosure Format/Delivery (Default- Paper/Mail) : Paper ___ Electronic : ___ (CD) ___ US Mail ___ Fax

I understand the following

- Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I understand this authorization is voluntary. Shawnee Health Service will not condition treatment, payment or enrollment in a health plan or eligibility for benefits on whether I authorize this release.
- I understand that this authorization will expire on _____ (enter date or event). In the event the date is not entered, this authorization will expire 6 months from date indicated below.
- I understand that I have the right to revoke this authorization at any time by notifying Shawnee Health Service in writing. This will not apply to records that have already been released. Send notice to: Privacy Officer, Shawnee Health Service, 109 California Street, Carterville, IL 62918-1923
- 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 also have the right to refuse to sign this authorization.
- Refusal to sign this release may result in delays in obtaining treatment or coordination of care.

_____ _____ _____ _____
Date (Signature of Client or Personal Representative) Date (Signature of 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** _____**Logged** _____