



Southern Illinois Medical Services

CNS

MRN

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION SIH Medical Group

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____ Maiden Name _____ Date of Birth ____/____/____ Last 4 SS _____

Purpose of Disclosure: ☐ Request of Patient ☐ Healthcare Treatment/Service ☐ Insurance ☐ Other _____

I authorize (name of SIH MG Provider/Clinic): _____

To disclose the below medical information to:

Name _____ Street Address _____ City _____ State _____ Zip _____

Specific information to be disclosed (check all that apply)

Date(s) of Treatment _____

☐ Office Visit Note	☐ Immunization Record	☐ Consultation Report	☐ Laboratory Reports	☐ Itemized Bills
☐ Physical	☐ Pathology Report	☐ Radiology Report	☐ Operative Reports	☐ Other: _____

Your medical and billing information may include sensitive information including but not limited to the examination, diagnosis, evaluation, treatment and or rehabilitation pertaining to a) alcohol and/or substance abuse, b) HIV/Aids, c) mental/behavioral health, d) development disability, e) sexually transmitted disease (STD); f) reproductive health.

I authorize disclosure of my sensitive information (check all that apply):

☐ Alcohol and/or Drug Abuse	☐ HIV/Aids	☐ Mental/Behavioral Health*	☐ Developmental Disability	☐ Sexually Transmitted Disease	☐ Reproductive Health
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I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand the revocation will not apply to information already released in response to this authorization.

This authorization will expire on ____/____/____ (*date is required for disclosure of mental/behavioral health information). If I do not specify an expiration date and the health information disclosed does not include mental/behavioral health information, I acknowledge this authorization is valid for 6 months from the date of my signature.

I understand the information (excluding mental health information, developmental disability, alcohol and substance abuse information, and/or HIV/Aids information) being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that substance use disclosure records of Part 2 programs disclosed pursuant to this consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

I agree a photocopy of this authorization is valid as the original.

Patients 12 – 17 years of age have authority to authorize disclosures for information pertaining to mental health and developmental disability, alcohol/drug abuse, HIV/Aids, STD's, reproductive health (abortion), criminal sexual assault or abuse.

Signature Patient/Patient's Legal Representative _____

Date _____

☐ I am the patient

☐ I am the Legal Representative of the Patient (complete a & b)

a)

First Name _____

Last Name _____

Phone Number _____

b) Relationship to Patient:

☐ Parent

☐ Guardian

☐ Legal Representative/Agent

Witness Signature (required for disclosure for mental health and developmental disabilities)

_____ Date: _____

Witness Printed Name _____

First Name _____

MI _____

Last Name _____