PERSONAL REPRESENTATIVE AUTHORIZATION

☐ **St. Joseph Memorial Hospital** ☐ **Memorial Hospital of Carbondale** ☐ **Herrin Hospital**

☐ **SIH Medical Group**

Note: This authorization is used to confirm YOUR request that Southern Illinois Healthcare/SIH Medical Group may discuss or disclose your protected health information to a particular person who acts as your Personal Representative.

Section A: PATIENT INFORMATION

By signing this authorization in Section E below, I understand and agree that Southern Illinois Healthcare/SIH Medical Group may release my personal health information to my Personal Representative(s) named in Section C below.

Patient Name: (Print)_____

Address:_____

Telephone Number: _____ Date of Birth: _____

Please Note: This authorization is not an advance directive and does not provide your "Personal Representative" identified on this form with any authority; either implied or direct, over any treatment or direct care decisions. I UNDERSTAND THAT I NEED NOT SIGN THIS FORM TO ENSURE HEALTHCARE TREATMENT.

Section B: TYPE OF INFORMATION

Information which will be available to the Personal Representative(s) includes, but is not limited to, identification of treating providers of care, diagnoses, testing results, procedures, demographic information. Information disclosed may also include information regarding developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS, however excludes disclosure of mental health or psychotherapy notes.

Section C: AUTHORIZED USE AND/OR DISCLOSURE

Intended Use or Disclosure:

I understand that it is not the general policy of SIH/SIH MG to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal health information and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative #1:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to you: _____

Personal Representative #2: (optional)

Name: _____ **Phone Number:** _____

Address: _____

Relationship to you: _____

Section D: EXPIRATION AND REVOCATION:

This authorization to release information to my Personal Representative will automatically expire 2 years after this authorization was dated below.

I understand that I have the 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 director of health information at Southern Illinois Healthcare or SIH Medical Group. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Health Information/Privacy Officer
Attn: Accounting for Disclosures
Southern Illinois Healthcare
1239 E. Main
Carbondale, IL 62901

Section E: SIGNATURE/AUTHORIZATION:

I have had full opportunity to read and consider the content of this Personal Representative Authorization. I confirm that this authorization is consistent with my request of Southern Illinois Healthcare and SIH Medical Group. I understand that, by signing this form, I am confirming my authorization that Southern Illinois Healthcare and SIH Medical Group may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature: _____ **Date:** _____ **Time:** _____

YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION.