MORRISON COMMUNITY HOSPITAL
Community Centered Care

303 N. Jackson Street
Morrison Illinois 61270
Phone: 815-772-4003
Fax: 815-772-7391

AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Authorization is given for the use or disclosure of the named individual's health information as described below. Morrison Community Hospital is authorized to make the disclosure or obtain PHI from another source. Please refer to the Morrison Community Hospital Notice of Privacy Practices.

Patient's Name: _____ MR#_____

Address: _____ Birth Date: _____

City, State: _____ Zip: _____ Telephone: _____

_____ Complete Records
____ Laboratory Reports
____ X-Ray Reports
____ X-Ray Films
____ Provider Records _____
[Name of Provider(s)]

____ Immunization Records
____ Other (Specify) _____
_____
_____
_____

Enter the Date(s) of service you would like information obtained or released: _____
(If no date entered, records for past 6 months will be sent.)

This information may be ***(circle one)*** **OBTAINED FROM or DISCLOSED/SENT TO** the following organization/individual:

Name: _____ Telephone: _____

Address: _____ **For the Purpose of**: _____

City, State _____ Zip: _____ Secure Fax number: _____

SPECIAL CONSENT: I authorize release of information relating to behavioral or mental health services, treatment for drug/alcohol abuse, physical assault/abuse/neglect, and/or sexually transmitted disease including AIDS/HIV. ***Circle one:*** **YES or NO**

I understand that:

- I may inspect or copy the information to be disclosed. The individual or company requesting the health information is responsible for appropriate copy charges.
- I have the right to revoke this authorization at any time and must do so in writing and present to the Health Information Department. Such revocation does not apply to information already released in response to this authorization.
- Unless otherwise revoked, this authorization expires on the following date, event, or condition: _____. If no expiration date, event, or condition is given, this authorization expires in sixty (60) days from date of request.
- Authorizing the disclosure of this health information is voluntary. My refusal to sign this authorization does not condition uses or disclosures of PHI permitted for treatment, payment, and healthcare operations.
- Disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____
If signed by Legal Representative, Relationship to Patient Witnessed By and Date

----- Office Use Only -----

Request Completed by: _____ Date: _____