LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

Release from:

Lawrence County Memorial Hospital
2200 State Street
Lawrenceville, IL 62439
Phone: 618-943-7226

AND/OR

Lawrence County Primary Care Clinic
2111 Lexington Ave
Lawrenceville, IL 62439
Fax: 618-943-7297

Release to:

Name _____ Telephone: _____

Address _____ Fax: _____

_____

Reason for release:

[ ] Continuing medical care
[ ] Claim for reimbursement
[ ] Litigation against third party other than the hospital, a hospital employee or physician
[ ] Litigation against the hospital, a hospital employee or physician (specify person): _____
[ ] At the request of the Patient or the Patient's Representative
[ ] Other: _____

Specified information to be released:

Dates of treatment: _____ Type of treatment: [ ] Inpatient [ ] Emergency room [ ] Outpatient

[ ] Face Sheet [ ] Consultation Report [ ] Emergency Room Report
[ ] History & Physical [ ] Operative Report [ ] Laboratory Reports
[ ] Discharge Summary [ ] Pathology Report [ ] X-ray Reports
[ ] Other (specify): _____

Authorization:

I understand that the information disclosed may contain testing or treatment information relating to Mental Health; Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulation.

I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Department.

I understand that refusal to sign this authorization does not condition treatment.

I understand that this authorization will expire ninety (90) days from the date signed unless otherwise specified.

Signature of Patient: _____ Date Signed: _____

Signature of Other Authorized Person* _____

Relationship to Patient or Authority to Act for Patient: _____

Signature of Witness: _____ Date Signed: _____

*Authorization must be signed by the parent or legal guardian of any patient under 18; the legal guardian of any patient under guardianship; the personal representative of a deceased patient, or if no personal representative, the spouse, any adult child of a deceased patient. If patient is under 18, records are protected by Federal Law (42 CRF, part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian.