Medical Record Number: _____

BHS Authorization for Release of Medical Information

Name of Patient: _____ Date of Birth: _____

Address: _____ Number to call: (_____) _____ - _____

Call when ready? (Circle) yes no (Circle) Pick up or Mail or Fax or Email Date of Request: _____ Date Needed: _____

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

RELEASE RECORDS FROM:

Name: _____

Address: _____

c/o Health Information Management

Telephone: _____ Fax: _____

RECORDS GOING TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

The type of information to be used or disclosed is as follows (check *all appropriate boxes* and details as needed):

Dates of Service/Treatment (MUST specify date range): _____

☐ Continuing Care Abstract (includes all physician dictation & radiology, lab and cardiology reports)

☐ Discharge Summary
☐ History and Physical
☐ Consultations
☐ Emergency Department Records
☐ Laboratory and Pathology Reports
☐ Radiology Reports
☐ Radiology Images
☐ Therapy Notes *(PT, ST, OT, Radiation, etc.)*
☐ Cardiology Reports *(EKG, ECHO, Cath, etc.)*
☐ Office Notes
☐ Immunization Records
☐ Operative Reports
☐ Physical Forms
☐ Workability or School Release Forms

☐ Other *(please specify)*: _____

I understand the information in my health record may include information relating to sexually transmitted disease (STD), genetic testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services even though I am protected by federal and state laws with respect to sensitive information.

Sensitive Medical Information

I specifically authorize release of the following sensitive medical information:

☐ Mental Health Records ☐ Genetic Testing ☐ STD/AIDS/HIV ☐ Drugs/Alcohol

Required Date Range: _____

****Witness signature is required below.**

If the patient is a minor, the patient must sign for the release of sensitive information. In Illinois, the patient must be at least 12 years of age. Contact HIM with any questions regarding minors.

I understand photo identification may be required to obtain medical records.

The purpose for which this disclosure is being made is:

☐ Personal reasons ☐ Legal ☐ Insurance ☐ Transferring care ☐ Continuity of care

☐ Other (please describe): _____

I understand I have the 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 Management Department. I understand the revocation will not apply to information that has already been released in response to this Authorization.

I understand once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. With the respect to sensitive medical information, no person or agency to whom any information is disclosed may re-disclose such information unless the person who consented to the disclosure specifically consents to such re-disclosure. I understand I have the right to inspect and copy the information that is to be disclosed.

This Authorization expires on: _____. (Default: 6 months) This Authorization is only valid for existing records. Future services will need a new Authorization.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the Authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information. Electronic images/records (i.e. Radiology) on CD/USB media are not encrypted or password-protected and are the sole responsibility of the recipient of the records to protect from unauthorized viewing. Unencrypted CD/USB media cannot be mailed by Blessing.

_____ _____ _____ _____

Date **Witness Date Signature of Patient or Legal Representative

_____ _____ Legal Representative Relationship (POA) _____

Date Minor (see page 2 for signature requirements)

BLESSING Health System

Guidelines for Completing
Authorization for Release of Medical Information

Name of Patient: Legal name of patient.

Medical Record Number: Number assigned to patient. For Staff Use Only.

Date of Request: The date information is being requested from Blessing Health System.

Date Needed: Only to be used as a guide for Blessing Health System on when a requesting party needs the requested information.

FROM: The entity in which an individual needs records from.

TO: Indicate where the medical records are needing to be sent.

Date of Service: Date of records needed, this can be a date range (i.e. "1999 to present", or specific lab report on 06/01/12.)

Record Boxes: Indicate which records are being requested, i.e. Operative Reports or Discharge Summaries. Please use "Other" if your specific item is not listed, such as billing.

Mental Health: Check this box if you had a behavioral or mental health evaluation or visit. A date range is required and there *must* be a witness signature. Children 12 and older residing in Illinois must also sign the release.

Legal Representative: May include parent, legal guardian, healthcare power of attorney, health care surrogate, etc.

Expiration: Any date can be written here. If left blank, 6 months will apply. Any medical visits you may have after date of signature will not be eligible for release with this Authorization. You must fill out a new Authorization once the services have been rendered.

Minor: State laws vary as to the age of minors and what minors can consent to. ***Contact HIM with any questions regarding minors.**

Once the form has been completed, the form is to be filed in the permanent medical record or sent to HIM.

☐ Blessing Health System
c/o HIM
P.O. Box 7005
Quincy, IL 62301
Phone: 217-223-8400, ext. 6600
Fax: 217-214-5890

☐ Hannibal Clinic Operations
c/o HIM
P.O. Box 311
Hannibal, MO 63401
Phone: 573-231-3196
Fax: 573-231-3705

☐ Denman Services, Inc.
c/o Patient Records
P.O. Box 40
Quincy, IL 62306
Phone: 217-277-5329
Fax: 217-224-9230

BLESSING Health System