Anderson Hospital
6812 State Route 162 – Suite 175 Maryville, IL 62062
(618) 391-6102 Release of Information
(618) 288- 0024 Fax

Information is to be released FROM:
ANDERSON HOSPITAL
6800 STATE ROUTE 162
MARYVILLE, IL 62062
618-391-6102

Information is to be released TO:
_____
_____
_____
Phone: _____

Patient Identification:
_____
(Printed Name)
_____
(Date of Birth)
__XXXX-XX-_____
(Last 4 of Social Security Number - Optional)

Information to be Released Covers the Time Frame
From Date: _____ To Date: _____

Please check the type of information to be released. ☐ Employee View Only Access Check Here

☐ Final Diagnosis	☐ X-ray Reports	☐ Mammogram with Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History / Physical	☐ EKG	☐ Emergency Record
☐ Consultation Reports	☐ Pathology Reports	☐ ENTIRE RECORD
☐ Operative Reports	☐ Progress Notes	☐

This information is being requested for the following purpose (s):

☐ Treatment or Consultation	☐ At the request of the patient	☐ Billing or Claims payment
☐ Comparison to Current Mammogram	☐ Other:	

I understand that:

- I may inspect and copy the information that I authorized to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above Attention Release of Information—Health Information Management Department.
- My refusal to consent to the use or disclosure of the above-mentioned information will prevent the disclosure of the information.
- If not revoked this authorization will expire 180 days from the date signed or _____(date expires).
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA. However this information will continue to be protected by Illinois Law.
- I understand by signing this release, **if applicable, *HIV/aids or genetic information, drugs/alcohol and /or mental health records* will be included.** (Check NO below if you do not want this information released.)
  ☐ NO. Specify the information NOT to be released: _____

By signing below, you authorize the release of your protected health information specified as above. I also understand that I will not be denied treatment if I do not provide authorization to use or disclose protected health information. A copy of the signed authorization will be provided.

_____ _____
Signature of patient or personal representative Date signed

_____.
If not signed by the patient, specify reason for signing, and relationship

_____ _____.
Signature of witness to above signing Date Signed