This form permits the release of information to a third party.

Authorization for Disclosure of Protected Health Information ("PHI")

Internal Use Only

Visit #:_________________M#:______________

Request #:______________ Pg. Count: ________

Photo ID Verified: ☐ Yes ☐ No Processed by________ (initials)

PHI to be disclosed from:
Anderson Hospital – HIM
6800 State Route 162, Suite 175
Maryville, IL 62062

Return Completed form by mailing to the address on the left, fax to **618-288-0024**, or email to healthinformation@andersonhospital.org, or drop off in person.

PHI to be disclosed to: ______________________ ______________________ ______________ __________ __________ ____________
Name Address City State ZIP Phone

Patient's Name:______________________________________ **Date of Birth**_______________________

Patient's Address/Phone: ____

Date(s) of service of PHI to be disclosed: From Date: ___________________ To Date: ___________________

Please specify PHI to be disclosed:

☐ Abstract (excludes consents, nursing notes, progress notes, physician orders, and MAR)
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ Cardiology Reports
☐ Laboratory Reports
☐ Pathology Reports
☐ Discharge Summary / Final Diagnosis
☐ EKG
☐ Emergency Report
☐ Imaging Reports
☐ Imaging Disc
☐ Pulmonary Report
☐ Progress Notes
☐ Physician Orders
☐ Complete Medical Record
☐ Sleep Study
☐ Medication Administration Record (MAR)
☐ Other (specify):
____
____

Please specify purpose of disclosure:

☐ Treatment or Consultation ☐ At the request of the patient ☐ Billing or Claims payment
☐ Legal ☐ Other: ____

I request that PHI be provided in the following format (if readily reproducible in this format):

☐ Paper Copy ☐ Mailed (to address below) ☐ Unsecure Fax (to fax number below)
☐ CD (UNENCRYPTED/ENCRYPTED, ***circle one***) ☐ E-Mail (to e-mail address below) (UNENCRYPTED/ENCRYPTED, ***circle one***)

I request that access to PHI be provided by the following method:

☐ Personal pick-up or inspection
☐ Mailed to the following address: ____
☐ Emailed to the following e-mail address: ______________________________________
☐ Faxed (unsecure) to: ____
☐ Other (specify) : ____

- I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to address above, Attention of Release of Information—Health Information Management Department, and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.
- I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization.
- If PHI to be disclosed contains information about drug/alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I agree to its release.
  Check if you do not agree to release of sensitive information described herein: ☐ **Do Not Agree**
  Specify the information NOT to be released: ________________________________
- Unless earlier revoked as provided herein, this Authorization will expire 180 days from the date of my signature below, unless a different expiration date/event is specified here________________________________.
- I agree to receiving copies of PHI through unencrypted methods such as, CDs, faxes, or emails from Anderson Healthcare or its Affiliated Covered Entities at the email address or fax number provided by me to Anderson Healthcare as indicated on this request. I understand that these means of communication may be unsecure and could potentially be intercepted and seen by others. By signing this request, I acknowledge and accept these risks and choose to receive unencrypted copies of PHI. I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law. I will be informed in advance of the approximate fee that may be charged for copies of PHI I requested.

By signing this Authorization, I hereby authorize disclosure of protected health information of above named patient as specified in this Authorization.

_______________________________________ ______________________ ______________________
Signature of Patient or Personal Representative Date Time

If this Authorization is signed by the patient's personal representative: Specify below the personal representative's printed name, indicate personal representative's authority to act on behalf of the patient and attach supporting documentation:

____
Personal Representative's Printed Name/Authority to Act on Behalf of Patient Named Above