



Memorial Hospital

One Ingalls Drive Harvey, Illinois 60426
708-333-2300

Patient Name: _____

Address: _____

City State Zip

Phone: _____

Birth date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize INGALLS MEMORIAL HOSPITAL
(Facility/Person releasing Information)

to release **MEDICAL RECORDS** of: _____
(Specific nature of information to be disclosed)

to: _____
(Receiving person or facility) (address)

The purpose or need for this disclosure:

(Continuing medical care, legal proceedings, insurance purposes, etc.)

I UNDERSTAND that my records are protected under the *Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDE: DIAGNOSIS, PROGNOSIS, AND TREATMENT FOR PHYSICAL OR PSYCHIATRIC ILLNESS, OR TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE, OR HIV TESTING FOR ANY ADMISSIONS.

I UNDERSTAND that I have the right to revoke this consent at any time by my submitting a written and dated notice for revocation to the facility releasing this information. If not revoked, this authorization is valid until _____; otherwise expires ninety (90) days from the date signed below.

I UNDERSTAND that if I refuse to consent to release of information, the records will not be released.

DATED: _____ **SIGNATURE:** _____
(Patient/Client/ Legal Guardian)

(If signature not of Patient/Client, specify legal relationship to patient)

DATED: _____ **WITNESS:** _____

*Federal Privacy Act U.S. Code, Chap. 5, Sect. 550) IL. REV. Statutes (Chap. 110, S-2001)

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

The information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.