



409 NW 9th Avenue
Aledo, IL 61231
(309) 582-5301

AUTHORIZATION TO RELEASE OF HEALTH INFORMATION

Please print (except signature) and specified health information will be release for the patient as indicated below, upon appropriate completion of this authorization.

Patient Name: _____ Maiden/Other: _____ Phone#: _____

Address: _____ Date of Birth: ___/___/___ SS#: ___/___/___

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to Mercer County Hospital. I understand that I do not have a right to revoke the authorization if it was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the insurance policy. If I choose to revoke authorization, I understand that I may be denied treatment, enrollment in a health plan, or eligibility for benefits. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

The type of information to be used or disclosed is as follows: (Check the appropriate boxes and include other information where indicated)

Date (s) of Service: _____

- Entire Record: _____
- Billing Information, specify _____
- Other: please specify _____

<p>I GIVE SPECIAL AUTHORIZATION FOR THE FOLLOWING HEALTH INFORMATION TO BE USED OR DISCLOSED:</p> <p><input type="checkbox"/> PSYCHOLOGICAL/PSYCHIATRIC/MENTAL HEALTH INFORMATION (THIS INCLUDES PSYCHOTHERAPY NOTES)</p> <p><input type="checkbox"/> HIV/AIDS INFORMATION</p> <p><input type="checkbox"/> SUBSTANCE ABUSE INFORMATION</p>

This authorization, for treatment date (s) indicated above, will expire one (1) year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)_____.

Disclose Health Information to Name: _____ Phone #: _____
Address: _____ Fax #: _____

- As per your request, the reason for release of health information is: Treatment Payment Self
- Legal Employer/Workers Comp. Other, specify _____

Signature of Patient or Legal Guardian Date

Relationship, if Not the Patient Witness Signature

Interoffice Use Only
Name of Employee Processing Request: _____ Date Processed: _____
Medical Records #/Account # _____