St. Margaret's Health

SMP Health System

Patient Name: _____

DOB: _____ MRN: _____

Authorization for Use and Disclosure
Health Information

www.aboutsmh.org

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birthdate:		**Medical Record Number:**	
Address:			
City:	**State:**	**Zip:**	**Phone:**

Method of Delivery: ____Mail ____Email (up to 30mbs) _____

____Other (e.g. electronic): _____

I authorize release of records from the following facilities:

☐ Peru Hospital ☐ Peru Clinics (please specify) _____

☐ Spring Valley Hospital ☐ Spring Valley Clinics (please specify)

Section II: INFORMATION REQUESTED and PURPOSE:

I authorize SMH to use or disclose the following health information during the term of this Authorization: (*check all that apply)*

- ❑ Clinic visit
- ❑ Emergency Room Report
- ❑ Surgical (operative report, path report)
- ❑ Hospital Records (Abstract)
- ❑ Radiology Images (Contact Medical Imaging 815-664-1469
- ❑ Test results (Specify:)_____
- ❑ Other: _____
- ❑ Billing records (Contact Patient Accounts @ 815-664-1575)
- ❑ Therapy Notes (Specify: PT, Speech),
- ❑ Mental Health Clinic Visit

  -OR-

  - ❑ Psychological Testing Final Report
  - ❑ Medication Ordered/Given
  - ❑ Other: _____

Dates of Treatment/Service:_____

For example: specific date 1/25/18; or range of dates Jan-July 2010; or all dates of service. If dates are not provided, SMH will only release the last 5 years of your medical record.

Are the Records Needed For An Appointment: ❑YES Appointment Date: _____

The Purpose/Need of the Disclosure: _____

Section III: RECIPIENT:

If this information is not being delivered to me, then deliver my health information to:

Name of Person: **EMAIL**	
Name of Organization:	**Fax Number**:
Street Address:	
City, State, Zip:	

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By checking any of the boxes below, I am specifically authorizing St. Margaret's Health to use and/or disclose the category of highly confidential information indicated next to the box, if applicable to this authorization.

- ❑ Information about a Mental Illness or Developmental Disability**
- ❑ Psychotherapy Notes (which are not part of the official medical record)
- ❑ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ❑ Information about Communicable Diseases
- ❑ Information about Sexually Transmitted Disease(s)
- ❑ Information about Substance (i.e., alcohol or drug) Abuse
- ❑ Information about Abuse of an Adult with a Disability
- ❑ Information about Sexual Assault
- ❑ Information about Child Abuse and Neglect
- ❑ Information about Genetic Testing
- ❑ Information about Infertility/IVF/Artificial Insemination

Section V: NOTICE TO PATIENT

I understand that this consent is valid for 90 days from the date of signature, or until calendar date _____/____/_____.

(This authorization request applies only to records with dates of service up to the date of signature, even if the valid date extends beyond the date of signature.)

Note: The term for mental health records must be stated—you may not use "no expiration." If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the Health Information Management Department. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that SMH has already taken action where it relied on my permission. *Send revocations to: Health Information Management Department, St. Margaret's Health, 925 West Street, Peru, Illinois 61354*. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, SMH cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. Illinois law does not allow the re-disclosure of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in defined situations allowed by law. Federal Confidentiality Rules, 42 CFR part 2, prohibits unauthorized disclosure of substance use records.

I have read and understand this Authorization and had a chance to ask questions about the disclosure of the health information. I authorize SMH to use/disclose my health information in the manner described above.

_____ _____

*Signature of Patient or Personal Representative** *Date*

_____ _____

Name of Personal Representative (If applicable)* *Relationship to Patient*

**The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

A witness signature is required for the release of information about a mental illness or developmental disability. Ages 12-17 Require Wittness Signature

_____ _____

Signature of Witness *Date*

_____

Printed Name of Witness

Return this form: Peru Requests
SMH-Peru
925 W. Street—HIM Department
Peru, Illinois 61354
Fax: 815-224-6743

Spring Valley Requests
SMH-Spring Valley
600 E. First Street
Spring Valley, Illinois 61362
Fax: 815-664-1169


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