Patient's Name: _____
Last *First* *Middle*

Home Address: _____

_____ **Telephone:** _____

Date of Birth _____ **SS#** _____ **-or- Drivers License#** _____

I, _____, authorize Methodist Medical Center of Illinois to disclose the following protected health information to: _____

ADDRESS: _____

___Complete Medical File		**___ I authorize the release of the following Highly Confidential Information**	
___Consultations	___Discharge Summary	___Mental Illness or Developmental Disability	___Sexual assault
___Lab Reports	___EKG Report	___Child abuse and Neglect	___HIV/AIDS Testing or Treatment
___X-ray Reports	___History & Physical	___Venereal Disease(s)	___Genetic Testing
___X-ray films	___ER Record	___Substance (i.e., alcohol or drugs) Abuse	
	___Procedure Reports	___Abuse of an Adult with a Disability	
Date of Service:			

TERM: This Authorization will remain in effect:
___For 90 days from the date of this Authorization.
___Until Methodist fulfills this request.
___Other: _____

PURPOSE: The protected health information is being used or disclosed for the following purpose(s):
___Transfer of Care ___Consultation with physician
___Legal consultation ___Insurance qualification
___Case Coordination ___Treatment Planning
___Other: _____

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that Methodist may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may revoke this authorization by notifying Methodist Health Information Services Department at 221 N.E. Glen Oak, Peoria, IL 61636 in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Methodist in reliance on it before I revoked it.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Methodist's treatment of me.

I understand that I may inspect or copy the protected health information to be used or disclosed as permitted under federal or state law.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Methodist to use or disclose my health information in the manner described above.

_____ _____ _____
Signature of Patient Date Signature of Witness*

Note: If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____ _____
Signature of Legal Guardian or other Legal Representative | Relationship to Patient | Date | Signature of Witness*

**Witness' Signature required for release of information about a mental illness or developmental disability.*

PATIENT STICKER

Methodist
AUTHORIZATION FOR RELEASE OF INFORMATION