AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

_____
Name Date of Birth Address City State Zip

2) AUTHORIZES: Boyd Healthcare Services, 800 School Street, Carrollton, IL 62016. Fax #217-942-9349

3) TO DISCLOSE TO: □ Self **Delivery Options:** □ Pick up at Boyd Healthcare Services □ Mail to address above □ Electronic Format

☐ E-mail to: _____

Note: Boyd Healthcare Services will automatically send email through encrypted/secured means.

Send To: ☐ _____
Name of Health Care Provider/Plan/Other

_____
Address City State Zip Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ Future dates will not be honored.
(Month/Year) (Month/Year)

5) INFORMATION TO BE DISCLOSED:

□ Discharge Summary □ Pathology Report(s) □ Emergency Record(s) □ History & Physical
□ Radiology Report(s) □ Itemized Billing Statement □ Consultation(s) □ Lab Report(s)
□ Operative Report(s) □ Cardiology Report(s) □ Progress Notes □ Treatment Plan(s)
□ Other records as specified: _____
□ Entire Medical Record (Except for Records Concerning Highly Confidential Information)

6) RELEASE OF HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of Highly Confidential Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box.

□ Mental Illness or Developmental Disability
□ Sexually Transmitted Diseases (STDs)
□ Sexual Assault
□ Substance Abuse (i.e., alcohol or drug)
□ Child Abuse and Neglect
□ Abuse of an Adult with a Disability
□ Genetic Testing
□ 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.

7) THIS AUTHORIZATION WILL REMAIN IN EFFECT:

□ From the date of this Authorization until: _____ (Not over one year)
□ Until the Releasing Entity fulfills the request or 120 days from the date of this Authorization is signed, whichever occurs earlier.

8) I understand that:

- The information disclosed pursuant to the Authorization may be subject to redisclosure by the Recipient and may no longer be protected by applicable federal and Illinois law.
- I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research-related or I am to receive healthcare solely for the purpose of creating protected health information for disclosure to the Recipient identified in the Authorization.
- I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately except to the extent the Releasing Entity acted in reliance on this authorization before it received the written notice of revocation.
- I may contact Boyd Healthcare Services' Health Information Management Department at 217-942-6520 or Boyd Healthcare Services' Privacy Officer by mail at Boyd Healthcare Services, 800 School Street, Carrollton, IL 62016 or by telephone at 217-942-6530.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

9) SIGNATURE OF PATIENT: _____ Date: _____
and/or
SIGNATURE OF LEGAL REPRESENTATIVE _____ Date: _____

WITNESS SIGNATURE (SUD/Mental Health IL Only): _____ Date: _____

If signed by a person other than the patient, complete the following:

1) **Individual is a** □ a minor (SUD exception) □ legally incompetent or incapacitated □ deceased.
2) **Legal authority**: □ a parent* □ legal guardian □ activated POA for Health Care □ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.