# Kane County Hospital
# Authorization to Use and Disclose Protected Health Information

| **Authorization to release the protected health information of (Please Print):** | |
|---|---|
| Patient Name: | Date of Birth: / / |
| Current Address: City State Zip | |
| Home Phone: ( ) Mobile Phone: ( ) | |

| **Person or Agency receiving the protected health information:** | |
|---|---|
| Name: | Phone Number: ( ) |
| Current Address: City State Zip | |

Delivered by: ☐ In Person – Date will be picked up _____/_____/_____
☐ Mail
☐ Fax – Fax Number ( ) _____ - _____
Electronic Delivery: ☐ Secure Email – Email Address _____

**The Purpose of this disclosure:**

☐ Self ☐ Other Provider / Continuity of Care ☐ Insurance
☐ Primary Care Provider ☐ Other _____

**Date(s) of Service requested:**

**Release the Following Information:**

***Patient Health Information*:**

☐ Lab Report(s)
☐ Pathology Report(s)
☐ Radiology Report(s)
☐ Emergency Record(s)
☐ EKG(s)
☐ Discharge Summary
☐ History & Physical
☐ Consultation(s)
☐ Operative/Procedure Report(s)
☐ Progress Notes
☐ Other Records as specified: _____

***Patient Billing information*:**

☐ Billing Record(s)

**This Authorization will expire 30 days from the date signed unless further specified:**

**I understand and agree:**

- Once *Kane County Hospital* discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to *Kane County Hospital* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR §164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the Health Information Management/Medical Record Department. If I revoke this Authorization, *Kane County Hospital* may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of *Kane County Hospital's* treatment of me.
- If I have any questions regarding the disclosure of my health information, I can contact the facility.
- There may be a charge for the copying and releasing of information and accept financial responsibility.

| **Signature of Patient/Personal Representative:** | **Date:** |
|---|---|
| **If Signed by Personal Representative, Relationship:** | **Signature of Witness: (optional)** |

**For Office Use Only:** **Date Completed:** _____ / _____ / _____ **MRN:** _____

**Completed By:** _____ **(Initials)** **Accepted By:** _____ **(Initials)**