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

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

The purpose of this disclosure:

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

Date(s) of service requested:

Release the Following Information:

***Patient Health Information*:**

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

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 I 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)*