Hopedale Hospital

Patient Consent to Release Hospital Medical Records and/or Billing Statements

NOTE: This form is NOT to be used for release of physician records or physician billing statements.
To request Medical Arts Physician medical records, please call (309) 449-4338

PLEASE PRINT LEGIBLY

_____ _____

Full Legal Name of Patient (REQUESTOR) Patient Date of Birth (required)

_____

Maiden Name or Prior Name (s)

_____

Patient Address: Street City State Zip Daytime Phone

Requesting Records **FROM**: Hopedale Hospital ("PROVIDER")
HIM Department (Medical Records)
107 Tremont St.
PO Box 267
Hopedale, IL 61747
Phone: (309) 449-4284
Fax: (309) 449-4087

Please Release (or Disclose) **TO**: _____ ("RECEIVER")
Name

_____
Street City State Zip

_____ _____
Telephone Fax (optional)

Reason for release/disclosure: _____
(optional) (such as: Patient treatment, insurance application, litigation, record transfer, etc.)

Specify Dates of Service FROM: _____ TO: _____ (required)

The specific type(s) of information to be disclosed (released) is as indicated (check):

◯	Inpatient Records	◯	Outpatient Records		
_____	History & Physical	_____	Lab Results	_____	Original Mammogram reports
_____	Discharge Summary	_____	X-ray Files and Reports	_____	MRI Films & Reports
_____	Operative Report	_____	CT Files & Reports	_____	Pathology Reports
_____	Emergency Department Record	_____	Progress Notes	_____	PT/Rehab Records
_____	Billing Statement(s)	_____	Nurses notes		

_____ Other (specify): _____

NOTE: The information disclosed may include highly confidential records regarding mental health, developmental disability, alcohol or drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious diseases, including HIV. However, if you wish to EXCLUDE such information from release, state which information is to be EXCLUDED here: _____

The Requestor, patient or the patient's authorized representative must read and initial the following statements:

1. I understand that I may ask to view and copy the information described on this form and that this authorization will expire on the following specific date, event, or condition related to the purpose of disclosure: _____. If no date is indicated here, the authorization will expire 6 months from the date signed. I understand that I may revoke this authorization at any time by notifying PROVIDER in writing, but the revocation will not affect any actions which may have been taken prior to the receipt of the written revocation. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment or payment or my eligibility for benefits.
   Initials: _____

2. I hereby authorize the use or disclosure of the patient's individually identifiable health information as described above. I have been made aware that if the RECEIVER re-discloses this information, it may no longer be protected by federal privacy regulations, and that the Hopedale Hospital, Hopedale Medical Foundation, Hopedale Medical Complex,

officers, directors, agents and employees are not responsible or liable for any consequences of such re-disclosure.
Initials: _____ **See Page 2**

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Patient name: _____

3. I understand that PROVIDER will not be responsible for any charges incurred for the reproduction of medical records by another health care provider or its contractors, as a result of this request. Any charges for complying with THIS request will be directed to the patient or his/her responsible party, if not paid in advance. Fee schedule for copies is available upon request. Initials: _____

4. For minor child releases ONLY: If patient is a minor child (under age 18), the undersigned states that he/she (requestor) is either the legally appointed guardian, or is the child's parent, and Requestor has not been denied access to the minor's medical records in any court proceeding and, to the Requestor's knowledge, is not currently under investigation by DCFS or any law enforcement agency.
Initials _____

_____
Signature of Patient or Requestor: (DO NOT SIGN THIS FORM IF BLANK)

_____ Date: _____
Print Name (and Relationship to Patient if not the Patient)

Witness: _____ Date: _____

NOTE: A valid Health Care Power of Attorney or proof of guardianship must be on file with PROVIDER if Requestor is signing on behalf of an adult patient who is under a disability or incapacitated.

Forward this completed authorization for processing to
Hopedale Hospital
HIM Department (Medical Records)
107 Tremont St.
PO Box 267
Hopedale, IL 61747
(309) 449-4284

NOTICE: THIS AUTHORIZATION IS NOT TO BE USED FOR RE-DISCLOSURES BY LAW.
This authorization does not allow **verbal** sharing of information by PROVIDER'S employees.
Facsimile reproductions of the signature are acceptable.