Hopedale Medical Complex

PATIENT'S CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)—ADULTS

Medical Records Department (309) 449-4288

ADULT PATIENT

PATIENT'S NAME (please print) _____ **DATE OF BIRTH**_____

PATIENT'S COMPLETE ADDRESS_____

The undersigned hereby authorizes use or disclosure of Protected Health Information (PHI) about the patient named above and described below.

1. Hopedale Medical Complex (HMC), including Hopedale Hospital, Hopedale Nursing Home, Medical Arts Physicians, Hopedale Pharmacy, Hopedale Wellness Center, Hopedale Commons and all its entities/employees are authorized to *use or disclose Protected Health Information (PHI)* about the patient. "PHI" includes individually identifiable information and medical records relating to the patient's health, healthcare provider, billing, insurance and demographic information.

2. The following person (or class of persons) *is authorized to **receive disclosure of*** **(PHI)** about the patient. His/her name, address and phone:
   (a) _____ (b) _____
   _____ _____
   _____ _____

3. The specific medical records/PHI that should be disclosed are (please give dates of service if possible):
   (a) **ALL PHI (initial here)** _____
   (b) **Only the following PHI**_____

NOTE: For hospital in-patients, HMC may release the patient's general condition (Good, Fair, etc.) to all persons inquiring (including family) unless you initial here: _____**NO, DO NOT DISCLOSE PATIENTS CONDITION.**

UNLESS YOU INITIAL HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: _____**YES, DISCLOSE THIS INFORMATION.**

4. The undersigned understands that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. The undersigned may revoke this authorization by notifying Hopedale Medical Complex Medical Records Department or the Chief Operating Officer. However, the undersigned understands that any action already taken in reliance on this authorization cannot be reversed, and a revocation will not affect those actions. The undersigned understands that HMC may not condition its treatment of the patient on whether or not this authorization is signed.

6. This authorization **expires 6 years from today's date,** and will remain valid even if Patient becomes incapacitated following signature. If Patient wants authorization to expire sooner or upon some future event, indicate here:_____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. You agree to pay said invoice within 30 days.

THIS FORM MUST BE COMPLETED BEFORE SIGNING.

_____	_____	_____
Signature of patient (The person about whom the information relates)	**Date of signature**	**Date of Birth or Social Security Number**

OR, if applicable-

_____	_____	_____
Signature of Guardian or Personal Representative of Patient	**Date of signature**	**Description of Authority to Act for the individual (POA, Guardian, Executor)**

** A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE GIVEN TO THE INDIVIDUAL OR OTHER SIGNATOR.*