Hopedale Medical Complex

PATIENT'S CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)—MINOR
Medical Records Department (309) 449-4288

NOT TO BE USED FOR MENTAL HEALTH SUBSTANCE ABUSE, HIV/AIDS OR RELATED TESTING

MINOR PATIENT ONLY

PATIENT'S (MINOR CHILD) 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) _____
   _____ _____
   _____ _____

NOTE: IF BOTH PARENTS OF MINOR CHILD ARE NOT TO HAVE ACCESS TO THE CHILD'S MEDICAL INFORMATION YOU MUST INITIAL HERE AND PROVDE HMC WITH A COPY OF SUPPORTING DOCUMENTATION (i.e. Order of Protection, divorce/custody order).

(a) NO-DO NOT RELEASE CHILD'S PHI TO HIS/HER FATHER/MOTHER (circle one) INITIAL _____
(b) List name/address of child's parent NOT to have access _____
_____

3. The specific medical records/PHI that should be disclosed are (please give dates of service if possible):
   (a) **ALL PHI except mental health, substance abuse, HIV/AIDS or related testing (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 PATIENT'S CONDITION.**

4. Purpose of Release (e.g. further care, insurance, attorney, etc.) _____

5. 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.

6. 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.

7. 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 **Date of signature** **Date of Birth or Social Security Number**
(The person about whom the information relates)

OR, if applicable-

_____ _____ _____
Signature of Parent Guardian of Minor Patient **Date of signature** **Description of Authority to Act for the individual (Parent or Guardian)**

Print Name_____

_____ _____
Witness signature **Date of Signature**

Print Name_____

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