# SWEDISHAMERICAN HEALTH SYSTEM

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ MRN _____
Current Address _____
Telephone _____ Date of Birth _____

**I HEREBY AUTHORIZE AND REQUEST (Check All that Apply)**

_____ SwedishAmerican Hospital _____ SwedishAmerican Home Care

_____ SwedishAmerican Medical Group (specify site) _____

_____ Other _____
(name of facility/person and address) _____
_____

**TO RELEASE, USE AND/OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:**

__ Entire medical record
__ Abstract of above only (includes dictated reports and diagnostic test results)
__ Medical Imaging Films (X-rays, CT, MRI, CINE)
__ Other (specify) _____

**RELATING TO THE FOLLOWING TREATMENT OR TIME PERIOD:**

From _____ (date) to _____ (date).

**THE INFORMATION MAY BE RELEASED TO** _____
(name of facility/person and address) _____
_____

**THE PURPOSE(S) OR NEED FOR THIS DISCLOSURE IS:**
☐ Medical Care ☐ Insurance Purposes ☐ Other

**EXPIRATION:** This authorization must be received within 90 days of the date of signature, and will expire one year from date of authorization, unless otherwise revoked by patient.

**FOR CLINIC USE ONLY:**
If transfer is due to patient discontinuing services of physician/clinic:
☐ Insurance Requirement ☐ Physician Availability
☐ Dissatisfaction ☐ Relocation ☐ Other _____

**PLEASE READ THE FOLLOWING CAREFULLY:**

*I understand* that I may revoke this Authorization in writing at any time, except to the extent information was released or other action taken in reliance on it, or if obtained as a condition of insurance coverage and the insurer has legal right to contest a claim or policy. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, SwedishAmerican Health System, 1401 E. State St., Rockford, IL 61104.

*I understand* that, with certain exceptions, health care providers and others may not condition treatment, payment, or enrollment or eligibility for health plan benefits, on obtaining an authorization. Exceptions may exist if authorization was sought for research-related treatment, for health care solely to create information to be disclosed to a third party (such as for a pre-employment or pre-enrollment physical), or health plan enrollment or eligibility. If such activity was conditioned on this Authorization, I understand that refusing to sign it may result in the refusal of such treatment, payment, or other activity. I understand that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for the underlying services.

*I understand* the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.

*I understand* that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information, and that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

*I understand* that I may refuse to sign this Authorization, and represent that no person has coerced or imposed any inappropriate conditions on my providing this Authorization. No other adverse consequences to me will result if I refuse to sign this authorization.

I understand that this authorization shall expire, without my express revocation, one year following the date of signature unless otherwise indicated. I further understand that my health information may be electronically stored on the computer, as well as in hard copy and can be accessed by physicians, medical support personnel and other health care providers at other facilities including SwedishAmerican Health System, who are authorized to participate in my care. I understand that I am authorizing the aforementioned information to be released orally, through copies of medical records and/or by fax.

*I hereby release and hold harmless* SwedishAmerican Health System, SwedishAmerican Hospital, affiliated organizations, clinics and home health agency, and their respective staff, providers, directors, officers, employees, agents, successors assigns and attorneys, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure or use of the information as identified above.

_____

Signature of Patient or Legal Representative Date

(Patients ages 12-17 may be required to sign and date with co-signature of parent/legal guardian)

_____

Co-Signature Date

_____

Signature of Witness Date