SIU MEDICINE

SIU Medical Record #_____

AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION
TO PERSONS INVOLVED IN MY CARE

Patient Name: _____ Date of Birth: ____/____/____
PLEASE PRINT

Address: _____ Daytime Phone: _____
City State Zip

I hereby give SIU my permission to release my medical information (including dental information) to the individual(s) specified below, upon their request. Methods of release may include verbal discussions or updates about my medical treatment, medications, or condition as requested. The purpose for these disclosures is to enable the person/s below to assist me in maintaining my health, and to participate in my medical care.

Name	Relationship to Patient	Date	Phone
Name	Relationship to Patient	Date	Phone

The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases, including HIV, and medical correspondence. Please check and initial the box for which you will authorize disclosure of information; and sign below.

- ❑ _____Mental Health
- ❑ _____Developmental Disability
- ❑ _____Alcohol or Drug Abuse
- ❑ _____Infectious Diseases Including HIV
- ❑ _____Genetic Testing
- ❑ _____Other

❑ I want this authorization applied to all SIU departments **OR**
❑ I only wish this authorization to apply to this specific SIU department: _____
Department Name

I understand that I may revoke this authorization at any time by notifying SIU in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the revocation. I understand that this authorization will continue until I revoke it. SIU may request a new authorization form be completed periodically.

I understand this authorization must be filled out completely, signed and dated in order to be processed.

I hereby authorize the use or disclosure of my individually identifiable medical information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure.

FORM MUST BE COMPLETED BEFORE SIGNING

Signature of Patient or Patient's Legal Representative	Date of Birth	Date
Signature of Witness		Date

Patient's Representative: _____ Relationship to Patient: _____
PLEASE PRINT

This form should be scanned into the patient's EHR and CB records. The Box under the Protected Health Info Tab in CB should be checked as well.

Revised 8.09; 1.10; 12.14, 6.17 Revised & Approved by Legal and Breach Committee: 1 .2015; Approved by Quality Risk & Safety: 5.2017; Approved by OCP 6.14.2017; Approved by Quality & Safety 6.20.17, revised 9.18.2017 approved by Legal 9.19.2017
(HIPAA Policy: 1.200 Auth. Verbal Release) (Facsimile reproductions of the signatures are acceptable)