AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name:_____ Medical Record #_____

Persons/organizations providing the information:

Washington County Hospital
705 South Grand Avenue
Nashville, IL 62263

Persons/organizations receiving the information:

_____
_____
_____

Specific description of information, including date(s) of service:

_____
_____
_____
_____
_____
_____

Purpose of the disclosure:

□ Continuum of Care □ Disability □ Self □ Attorney

Patient hereby acknowledges that he/she understands that treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on his/her signing of this authorization. However, Washington County Hospital may condition the provision of health care that is solely for the purpose of creating protected health information on Patient's signing of this authorization and WCH may condition the provision of research related treatment on Patient's signing of this authorization for the use and disclosure of protected health information created for research that includes treatment of the individual.

The patient or the patient's representative must read and sign below:

I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form.

I understand that I will receive a copy of this form.

I understand that this authorization will expire on _____(DD/MM/YY)

I understand that I may revoke this authorization at any time by notifying Washington County Hospital in writing, except to the extent that they have already used or disclosed information in reliance on this authorization.

Email Disclaimer: Please be advised that email is not secure and there is a risk that these emails could be read by a third party. Washington County Hospital is not responsible for unauthorized access of protected health information while in transmission to the email account provided to us with the request for release, or after delivery to said account.

Email Address:_____

Signature of patient or patient's representative: _____ Date:_____

Printed name of patient's representative:_____

Relationship to the patient: □ Parent □ POA □ Other_____

Identity Verified: □ Email Disclaimer Read □ Initials:_____