

FAMILY PHYSICIANS OF O'FALLON, P.C.
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____
Last
First
Middle

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

REASON FOR REQUEST (specialist visit, transferring doctors, etc): _____

SPECIFY INFORMATION TO BE DISCLOSED: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

The information next to the boxes below (with the exception of Psychotherapy Notes) may be included when you authorize the release of your records. If you **DO NOT** want this information released, please check the appropriate box below:

- Information about a Mental Illness or Developmental Disability
- Psychotherapy Notes
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s)
- Information about Substance (i.e., alcohol or drug) Abuse
- Information about Abuse of an Adult with a Disability
- Information about Sexual Assault
- Information about Child Abuse and Neglect
- Information about Genetic Testing

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information: _____

Address of the recipient or where my health information should be delivered: _____

TERM: This Authorization will remain in effect:

- Until I revoke it in writing.
- From the date of this Authorization until the _____ day of _____, 200__.
- Until the following event occurs: _____.
- Other: _____.

I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Practice's Privacy Officer or Practice Manager by mail at **310 N. Seven Hills Rd., O'Fallon, IL 62269**, and I may contact the Privacy Officer or Practice Manager by telephone at **(618) 624-6181**.

I have read and understand the terms of this Authorization and had I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient

Date

Signature of Witness*

**Witness' Signature required for release of information about a mental illness or developmental disability*

Note: If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative

Relationship to Patient

Date

Witness*

**Witness' Signature required for release of information about a mental illness or developmental disability*

[Copy of Signed Authorization To Be Given to Patient]