HIPAA PRIVACY AUTHORIZATION

Disclosure of Protected Health Information

Patient's Name: _____

Address:_____ Date of Birth: _____

Date of Incident and Location: _____

1. I make this Authorization for the following purpose(s): _____ _____.

2. This authorization is directed to and applies to protected health information maintained by: (The City of Park Ridge)_____.

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, and medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless otherwise specified, relating to my care and treatment including x-rays, photographs, electronic and digital files and other records, unless I expressly direct or specify otherwise, I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2, psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

4. Copies of these records are to be released to: _____ or their agent, _____.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

6. This authorization shall expire on _____ or within 180 days of the date of this authorization if no specific expiration is included in this paragraph.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor, or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.

9. A copy of this authorization is as valid as the original.

10. The authorization cannot be faxed and must be mailed or personally delivered.

All Pertinent Sections Of This Form Must Be Completed Before Signing

Subscribed and sworn before me this _____ day of _____, 200___.

_____Notary
_____County, IL

My commission expires _____

_____
Signature of Patient or Legal Representative
Date: _____

_____
Print Name of Patient or Legal Representative

_____
Description of Legal Representative's Authority or Relationship