CLAY COUNTY HOSPITAL AND MEDICAL CLINICS
911 Stacy Burk Drive • Flora, IL 62839
618.662.2131

○ CCH Clinics (Flora, Louisville, Clay City)
Phone: 618-662-2131 Fax: 618-662-3077

○ Clay County Hospital (911 Stacy Burk Dr)
Phone: 618-662-2131 Fax: 618-662-1610

Patient Request for Health Information

Please note it could take up to 30 days for request to be processed.

Patient First Name:	Middle Initial:	Last Name:
Date of Birth:	Phone #	Email (Optional):
Street	City, State	Zip

Records being requested:

Purpose of release: ☐ Treatment ☐ Insurance ☐ Consultation Other/Legal _____

(Check appropriate boxes below): Date(s) of Service: ____/____/____ through ____/____/____

- ❑ Discharge Summary
- ❑ Emergency Room Records
- ❑ Operative/Procedure Reports
- ❑ Billing Records
- ❑ Other (Immunization Records, Med Lists) Please specify:_____
- ☐ Progress notes
- ☐ Radiology Reports
- ☐ Entire Chart
- ☐ Lab/Pathology Reports

I Specifically authorize the release of information related to: SIGNATURE REQUIRED IF REQUESTING THESE!

O Substance use disorder (Including alcohol/drug)
(please be specific about what is requested)
O Behavioral/Mental Health Records
O HIV related information (AIDS related testing)

_____

Patient/Personal Representative

(see attached disclosure age 12-17) (12-17 must sign for self)

How would you like your records delivered?

❑ Paper ☐ Mail ☐ In-Person Pickup

❑ Electronic (Email, CD, Portal, Other) Please specify: _____

Where do you want the information sent or requested from? (Fill in boxes below): Obtain/disclose Purpose of release

- ❑ Self
- ❑ Personal Representative (indicated below)
- ❑ Provider/Facility (Indicated below)
- ❑ Requesting records from another provider/facility (Specify Below) (multiple facilities require separate forms)

Name: Facility: Address:	Phone: Fax:

Patient/Legal Representative Signature: _____DATE: _____

Relationship: _____

Witness: _____ _____ _____

Printed Name Signature Date

Records Received by: _____DATE: _____ ID VERIFIED: _____

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ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand that this authorization includes disclosing information regarding mental, developmental disability, sexually transmitted disease, alcohol and/or drug use disorder, reproductive health services, and or HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation. See below further disclosures for these services

• I understand the expiration date of this authorization is 90 days unless otherwise specified. At the end of research study; not applicable for ongoing research.

• I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

• I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal or State privacy regulations.

• By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

• I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it.

• I understand my request will be acted upon within 30 days. An extension of 30 days may be requested if CCH needs more time to fulfill request. If I am not provided with access or information cannot be supplied, I understand I will be notified and have the right to request review of any denial of access other than those made in accordance with applicable law.

• I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

• CCH believes that the only way to avoid third party interception of information sent through e-mail is to send such information by encrypted e-mail. Despite this warning about the risk that my protected health information could be read/intercepted by a third party if it is not sent by encrypted e-mail, I request CCH to send an electronic copy (if available) of the requested information by unencrypted e-mail.

NOTE TO RECIPIENT OF DRUG AND ALCOHOL USE DISORDER INFORMATION:

The information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ILLINOIS HOSPITAL:

I understand the consequences of refusal to release any information will be the responsibility of the patient/legal guardian and Clay County Hospital will not be held liable.

NOTE TO RECIPIENT OF MENTAL HEALTH INFORMATION:

Under the provision of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not redisclose any of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Mental Health Information for Minors Disclosures:

Illinois law permits minors age 12 and older to receive a limited amount of counseling services or psychotherapy on an outpatient basis without parental consent, and providers are prohibited from notifying the minor's parents without the minor's consent "unless the facility director believes such disclosure is necessary," in which case the minor must be informed. Mental Health and Developmental Disabilities Code, 405 ILCS 5/3-301.

Minors aged 16 and older may be admitted to a mental health facility and treated as an adult; however, in that case, parental consent is required. Mental Health and Developmental Disabilities Code, 405 ILCS 5/3-302.

Under Illinois law, minors age 12 through 17 have the right to access and authorize release of their own mental health and developmental disabilities records and information, and their parents have such rights only if the minor does not object or the therapist does not feel there are compelling reasons to deny parental access. (Nonetheless, parents may receive information regarding the minor's physical and mental condition, diagnosis, treatment needs, services provided/needed, and medication.). Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/5.

Note to Recipient Reproductive Health Information

The Final Rule continues to permit covered health care providers, health plans, or health care clearinghouses (or business associates) to use or disclose PHI for purposes otherwise permitted under the Privacy Rule where the request for the use or disclosure of PHI is <u>not</u> made to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.

Note to Recipient of HIV/AIDS Testing, results, and/or treatment

Limiting the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish an intended purpose, when being transmitted by or on behalf of a covered entity under HIPAA, is a key component of health information privacy. The disclosure of HIV-related information, when allowed by this Act, shall be performed in accordance with the minimum necessary standard when required under HIPAA.410 ILCS 305/2