MEMORIAL HOSPITAL | BJC HealthCare

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize/request

☐ Memorial Hospital Belleville
4500 Memorial Drive
Belleville, IL 62226

☐ Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269

☐ Memorial Care Center
4315 Memorial Drive
Belleville, IL 62226

to release medical information of: _____
(Patient's Full Name)

Former Name(s) (where applicable):_____

Date of Birth: _____ Social Security Number: _____

I request only the following information to be released:

- ☐ Designated Record Set
- ☐ Emergency Report
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory (specify) _____
- ☐ Other (specify) _____
- ☐ Itemized Billing Statement
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Mammograms
- ☐ Cardiac Cath Lab Cine Film
- ☐ Cardiac Cath Lab Reports
- ☐ EKG
- ☐ Pharmacy Records

Date(s) of Treatment:_____

Release or Mail To: _____
(Individual/Physician/Institution/Agency)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

For the purpose of: _____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Memorial, BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

(continued on back)

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I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire one hundred eighty (180) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative.

If this Authorization is being presented pursuant to litigation, complete this section.
If this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports and other medical documents in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRIs and CT scans and post-mortem records, if applicable, **PROVIDED** that the examinations, treatments and/or tests involve or relate to complaints, injuries, illnesses and/or conditions pertaining to the following alleged injury:

_____

[insert allegation from petition which describes injured part(s) of body]

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability.

This authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

NOTE: Records will be mailed to above address unless otherwise noted below.

Signature of Patient/Legal Guardian/Personal Representative	Date	Time
If someone else signs on behalf of the patient, state your relationship to the patient	Date	Time
Witness	Date	Time

NOTE:
If above address is not patient's, please complete the following:

Patient Address: _____

Check if Patient will pick up copies at Memorial: ☐

Facility Use Only: *Date Request Granted:*_____

*Other Disposition (Date/Action):*_____