

**AUTHORIZATION**  
TO USE AND DISCLOSE HEALTH INFORMATION

**Provena Health**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_  
**Telephone Number:** ( ) \_\_\_\_\_ **Master Patient Index Number:** \_\_\_\_\_

I hereby authorize the use and disclosure of the individually identifiable health information about me that is described below by Provena Health for the specific purposes listed below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below, and that Provena Health is not receiving any remuneration from any third parties as a result of this use or disclosure of information.

I understand that Provena Health may not and will not condition health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits, upon my signing this authorization for the requested use and disclosure. I further understand that if the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In such a case, the information may be redisclosed by the recipient to others for other purposes. I understand that I may, at any time, inspect or obtain a copy of the information about me that will be used and disclosed, as described below, by mailing a written request to, or presenting it in person at, any Provena Health facility.

**Specific description of health information to be used or disclosed:**

\_\_\_\_\_  
*(e.g., if not specifically limited or restricted, the types of information to be used or disclosed may include medical, psychiatric, or psychological records, records of evaluation and treatment for alcohol or drug abuse\*, records and results of HTLV-III, HIV, or AIDS testing, etc.)*

**Approximate dates of treatment:**

\_\_\_\_\_

**Purpose of the use or disclosure:**

\_\_\_\_\_  
*(e.g. further care, insurance claim, attorney inquiry, at the request of the individual, personal use, etc.)*

**Persons or organizations using or disclosing the information:**

\_\_\_\_\_

**Persons or organizations receiving the information:**

\_\_\_\_\_

I understand that my decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and that I may refuse to sign this form. I understand that I may revoke this authorization, in writing, at any time. However, such a revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law. I may make such a written revocation by mailing it to, or presenting it in person at, any Provena Health facility. I also understand that I may request a copy of Provena Health's Notice of Privacy Practices, or ask any other questions, by calling Provena Health's **AlertLine**, at **1-800-93-ALERT**, or the Medical Records Department of the Provena Health facility where I receive treatment, at any time, in order to learn more about how information about me is used or disclosed by Provena Health or about revocation of this authorization.

Unless revoked by me sooner or limited or restricted to a shorter time period by applicable law, this authorization shall be effective for \_\_\_\_\_ **days/months/years (complete blank and circle appropriate period)** after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below, and if signing in person at a Provena Health facility, I will ask for such a copy, if one is not provided, before I leave.

**I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:**

<i>Signature of Patient or Legally Authorized Representative</i>	<i>Date</i>
<i>If not Patient, then Relationship of Legally Authorized Representative to Patient</i>	
<i>Signature of Witness</i>	<i>Date</i>

**Provena St. Mary's Hospital** Attn: Health Information Management  
500 West Court Street  
Kankakee, Illinois 60901  
815-937-2440 Fax: 815-937-5738

\* Notice to Recipients of Alcohol & Drug Abuse Information: The confidentiality of alcohol and drug abuse patient records maintained by Provena Health, and disclosed to you pursuant to this under this authorization, is protected by Federal law and regulations (*see* 42 U.S.C. § 290dd-3 and 290ee-3, and 42 C.F.R. pt. 2). Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime. Suspected violations should be promptly reported to appropriate authorities, in accordance with Federal regulations. Federal laws and regulations do not protect any information about a crime committed by a patient or about any threat to commit a crime. Federal laws and regulations also do not protect information about suspected child abuse or neglect from being reported under State law or regulations to the appropriate State or local authorities.