Hammond-Henry Hospital
Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I,_____, _____
(Name) (Date of birth)

authorize,_____, to disclose the following information
(Name of Institution)

to Hammond-Henry Hospital Medical Group: ❑ Geneseo ❑ Cambridge ❑ Kewanee ❑ Port Byron
(Person Receiving the Information)

for the purpose of _____
(Continued Care, Legal Proceedings, Insurance Billing)

Medical records or other information regarding my treatment, hospitalization, and/or outpatient care.

- ❑ History & Physical, Consultations
- ❑ Operative Reports, Discharge Summary
- ❑ Lab, X-Ray, EKG, EEG, Testing, etc.
- ❑ Other _____
- ❑ Psychological Evaluation
- ❑ Psychological Examination
- ❑ Entire Record

This information is for the hospitalization and/or outpatient visit from:_____to _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychological or psychiatric impairments, substance abuse, child abuse, spousal abuse, elderly abuse, rape, or adoption.

I understand this information may be re-disclosed by the person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization or to information required by the Privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand the medical record is protected under the Federal Confidentiality Regulation and cannot be disclosed without the patient's written consent unless otherwise provided for in the regulations.

I understand that I may request to inspect the information to be released.

I understand this authorization shall automatically expire without my expressed revocation 90 days from the date of signing or on_____.

_____ _____
Signature of patient or Legal Representative Date

_____ _____
If signed by Legal Representative, relationship Signature of witness

RELEASE

F-2077 (10/17)
Revised (5/20/19, 1/20, 2/20, 7/20, 9/21)

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Cambridge: 106 North East Street | Cambridge, Illinois 61238 | Phone: (309) 937-3560 | Fax: (309) 946-9265
Kewanee: 1258 West South Street | Kewanee, Illinois 61443 | Phone: (309) 853-3677 | Fax: (309) 946-9292
Port Byron: 105 North Main Street | Port Bryon, Illinois 61275 | Phone: (309) 523-2015 | Fax: (309) 946-9225