AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (RELEASE)
GENESIS HEALTH SYSTEM
[ ] GMC – Aledo, IL [ ] GMC - Davenport, IA [ ] GMC - DeWitt, IA [ ] GMC - Silvis, IL

DISCLOSING ENTITY: [ ] Genesis Health System [ ] Other Health Care Provider

I, _____, authorize _____ **(disclosing entity)** to use or disclose my health information (including the highly confidential information I selected below, if any) during the term of this Authorization for the following specific purpose(s):

_____

_____

RECIPIENT: Name and address of person(s) or entity to whom **Genesis Health System Affiliated Entities** may disclose my health information:

_____

_____

_____

SPECIFY INFORMATION TO BE DISCLOSED (including the dates of the information): _____

_____

_____

_____

TERM: This Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20 ____
- ☐ Until Genesis Health System Affiliated Entities fulfills this request.
- ☐ Until the following event occurs: _____
- ☐ Other: _____

MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of this type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization.

- Mental Health Treatment: _____
- HIV/AIDS Testing or Treatment: _____
- Sexually Transmitted and Venereal Disease Information: _____
- Substance Abuse (Drug and Alcohol Evaluation and Treatment: _____
- Child Abuse and Neglect: _____
- Information about Sexual Assault: _____
- Information about Genetic Testing: _____

ADDITIONAL HIGHLY CONFIDENTIAL INFORMATION PER ILLINOIS LAW

- Information about Abuse of an Adult with a Disability: _____

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I understand that once **Genesis Health System Affiliated Entities** discloses my health information to the recipient, **Genesis Health System Affiliated Entities** cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that **Genesis Health System Affiliated Entities** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **Genesis Health System Affiliated Entities**;

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the **Genesis Health System Corporate Privacy Office** at the address listed below. The revocation will be effective immediately upon the receipt of my written notice by the **Genesis Health Systems' Corporate Privacy Office**, except that the revocation will not have any effect on any action taken by **Genesis Health System Affiliated Entities** in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Genesis Health System Affiliated Entities to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

If the patient is a minor or otherwise incapable of signing this Authorization, obtain the following signature:

_____ _____ _____

Signature of Personal Representative **Description of Authority** **Date**

Patient's Name: _____

Last First Middle

Home Address: _____

_____

Home Telephone: (_____)_____ Date of Birth: _____

_____ _____

Witness Date

Information was ☐ **Given to patient** ☐ **Faxed** ☐ **Other:**_____

Information was released in the form of: ☐ **Print** ☐ **Verbal** ☐ **Audio** ☐ **Video** ☐ **Electronic**

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(Tab – Miscellaneous)