

**BLOOMINGTON MEADOWS HOSPITAL**

**AUTHORIZATION FOR USE OR RELEASE OF INFORMATION  
COMPREHENSIVE**

**FOR THE RECIPIENT OF THE INFORMATION:**

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the **obtaining or releasing** 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.

\*

I, \_\_\_\_\_ \*

(Name of Patient)

(Date of Birth)

\*

\_\_\_\_\_

(Address)

hereby authorize BLOOMINGTON MEADOWS HOSPITAL to **obtain or release** specified confidential medical, psychiatric (including alcohol and/or drug), HIV/AIDS test results or diagnoses, and/or educational information obtained in the diagnosis and treatment at the hospital to the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information, and I understand that BLOOMINGTON MEADOWS HOSPITAL will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

(If info may be released, **must** mark "yes" and initial)

\*

**Please check Yes, No or Not applicable for each category listed.**

**REFERRAL SOURCE**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_  
(Individual Name and/or Agency Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care.  
**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

**THERAPIST**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_

(Individual Name and/or Agency Name and Address)  
**Purpose:** To aid in the success of treatment, to provide continuity of care.  
**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

**PSYCHIATRIST**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_

(Individual Name and/or Agency Name and Address)  
**Purpose:** To aid in the success of treatment, to provide continuity of care.  
**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

**SCHOOL**       Yes     No     Not applicable      Initial if Yes \_\_\_\_\_  
(School Name and Contact Name)

**Purpose:** Coordinator of services; educational planning  
**Information to Use or Release:** Discharge summary (e.g. medication), Educational records, Other \_\_\_\_\_

\* Name of Patient: \_\_\_\_\_

**EMPLOYER**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Employer Name and Address)

**Purpose:** For verification of admission and stay in the hospital and/or insurance coverage benefits.

**Information to Use or Release:** Admission/Discharge Notification, Admitting Diagnosis, FMLA Paperwork, Other \_\_\_\_\_

**FAMILY PHYSICIAN**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care.

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluations, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

**FAMILY MEMBER**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name, Relationship and Address)

**Purpose:** To aid in the success of treatment.

**Information to Use or Release:** Admission/Discharge Notification, progress reports, discharge planning, family counseling, Other \_\_\_\_\_

\* **EMERGENCY CONTACT**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name, Relationship, Telephone Number)

**Purpose:** To notify emergency contact the status of patient if deemed necessary by physician.

**Information to Use or Release:** Patient hospitalization, progress reports, Other \_\_\_\_\_

**EAP OR LEGAL**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

**OTHER**                       Yes     No     Not applicable                      Initial if Yes \_\_\_\_\_

\_\_\_\_\_  
(Name and Address)

**Purpose:** To aid in the success of treatment, to provide continuity of care

**Information to Use or Release:** Admission/Discharge Notification, Interim Reports, Psychiatric Evaluation, Psychological Testing (if done) Discharge Summaries, Aftercare Plan, Other \_\_\_\_\_

\* Name of Patient: \_\_\_\_\_

The treatment dates covered by this authorization are from preadmission to discharge and claims resolution. This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release BLOOMINGTON MEADOWS HOSPITAL from all liability that may arise from the use or disclosure of medical records in reliance on this authorization. **If patient is a minor, relevant state law should be followed with respect to the required signators.**

If any information may be faxed, must mark "yes" and initial.

If requested information may be faxed.  Yes  No Initial if Yes \_\_\_\_\_

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire upon occurrence of the following event or condition. If none are checked, the authorization will expire 180 days past date of signature.
  - 180 days past termination of services at Bloomington Meadows Hospital from the date this authorization is signed or
  - at the happening of the following event or date (less than 180 days from date signed):

\_\_\_\_\_

2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that BLOOMINGTON MEADOWS HOSPITAL will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):
  - \*  The patient, and the identification that I have provided is true and correct.
  - \*  The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:   
\* \_\_\_\_\_".
5. **Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

Must mark one of the boxes in #4. If rep, must indicate relationship

\* \_\_\_\_\_  
(Patient Signature) (Age 12 and Over Should Sign)

\* \_\_\_\_\_  
(Date)

\* \_\_\_\_\_  
(Parent/Guardian/Personal Representative Signature)

\* \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

(INTERNAL USE ONLY)

I have received \_\_\_\_\_ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Printed Name)