



Patient Authorization for Use and Disclosure of Protected Health Information

This authorization permits CMH Clinics to use and/or disclose the following individually identifiable health information about me to the below listed individuals (specifically describe the information to be used or disclosed, such as date(s) of services, type of service(s), level of detail to be released, origin of information, etc.): ALL information, unless otherwise specified STD Testing Testing and/or Confirmation of Pregnancy HIV Testing Alcohol testing/treatment Drug testing/treatment Mental Health Other: _____

The information will be used or disclosed for the following purpose: continuum of medical care/emergency situations. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from CMH Clinic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: CMH Clinics, 1000 N Allen St, Robinson, IL 62454.

The following designated parties have AUTHORIZATION to my personal health information and are my Emergency Contacts:

Designated Party Name: _____ Date of Birth: _____ Male/Female
Address: _____
Phone Number(s): _____
Relationship to Patient: _____

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Address: _____
Phone Number(s): _____
Relationship to Patient: _____

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Phone Number(s): _____
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Designated Party Name: _____ Date of Birth: _____ Male/Female
Address: _____
Phone Number(s): _____
Relationship to Patient: _____

Patient Printed Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____