HSHS Good Shepherd Hospital
Shelbyville, Illinois 62565

SPECIAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

HSHS Good Shepherd Hospital

CONFIDENTIAL INFORMATION

I, (patient's name)_____, (date of birth) _____

Do hereby consent to and authorize _____ to

disclose to _____ information

from the Hospital records of (specific date(s):_____.

I understand that the specific type of information to be disclosed includes:

_____ and that

the purpose or need for this disclosure is to _____

_____

I understand that I have the right to inspect and have copies of the information that I authorize to be disclosed. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon and that this consent will expire ninety days from the date signed.

Dated this_____day of _____ 20___

Witness: _____ Signature:_____
Patient

Witness: _____ Signature:_____
Parent, guardian or authorized legal representative

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from the records which confidentiality is protected by Federal or State law. Federal or State regulations prohibit you from making further disclosure of this information without the specific consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization is not sufficient for this purpose.

NOTICE TO PATIENT: The individual has the right to revoke this authorization in writing to the extent HSHS Good Shepherd Hospital has not relied on this authorization in the release of information. Please refer to HSHS Good Shepherd Hospital's Privacy Notice for additional instructions.

FORM #157