Printed Name: _____ Date: _____/_____/_____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information (or personal information) may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I further understand that I may request a copy of this authorization.

I Authorize the following Health Information (or personal information) to be Used and/or Disclosed:

□ First Name	□ Date of Birth/Age
□ Last Name	□ Relating personal life experiences and relationships of myself and/or my family and friends
□ City	
□ State	□ Any information relevant to my condition or treatment
□ Diagnosis	

I Authorize the following Persons/Organizations to Use and/or Disclose My Health Information (or personal information):

Hospice of Southern Illinois

I Authorize the following Person/Organizations to Receive and/or Use my Health Information (or personal information):

Communities Served by Hospice of Southern Illinois, Employees, Volunteers, and the Public at Large/General Public.

I Authorize my health Information (or personal information) to be Used and/or Disclosed for the following situations and for the following purposes.

I specifically authorize the use of my information in the form of photographing, videotaping, interviewing, social media (i.e. Facebook, Twitter, YouTube, Pinterest, Blogger/Blogging, and others.), print media, email, publishing, or broadcasting to public at large/general public. This information will be used, with *respect and dignity to our patients and their families*, for any medium for educational, promotional, public relations, marketing, advertising, staff education and/or other purposes that support the mission of Hospice of Southern Illinois.

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing to the Hospice of Southern Illinois Privacy Officer. Send to 305 S Illinois St. Belleville, IL 62220. I also understand that any uses or disclosures already made with my permission cannot be taken back.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information (or personal information) disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information (or personal information) without obtaining my authorization.

Additional Patient Section Only:

Date of Birth: _____/_____/_____ Patient Number: _____

Unless otherwise revoked, this authorization will expire on the following date or event. If I fail to specify an expiration date or event, this authorization will expire 10 years from the signature date. Specified date or event: _____

If patient is unable to sign, complete the following:
Name of Personal Representative and Relationship to Patient: _____

_____	_____	_____
Signature of Personal Representative	Authority of Personal Representative	Phone Number

Patient was unable to sign because: _____

Signature: _____ Phone Number: _____

PATIENT/NON PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION