AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed patient name: _____ Date of birth: _____

Address: _____ Telephone number: (_____)_____

City: _____ State: _____ Zip code: _____

I hereby authorize ST. ALEXIUS MEDICAL CENTER (facility name) to release the protected health information indicated below on the above named individual to :

RECORDS DEPOSITION SERVICE, INC.

Provider name/Organization/Individual

120 W. MADISON STREET, STE. 300

Full address of provider/Organization/Individual

Fax number: (312) 553-8901

City: CHICAGO State: IL Zip code: 60602 Telephone number: (312) 553-8900

For the following purpose: ☐ Physician or health care facility ☒ Legal purposes ☐ Personal use ☐ At the request of the individual

☐ Other _____

For treatment date(s) or service _____

Expiration date or expiration event: _____

(If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days from the date signed below.)

INFORMATION TO BE DISCLOSED: **Date/time information needed** _____

☐ Abstract chart (includes face sheet, discharge summary, history and physical, consultation reports, operative reports, diagnostic tests)
☐ Entire medical record
☐ History and physical ☐ Consultation ☐ Operative report ☐ Discharge summary ☐ X-ray copies ☐ X-ray originals*

Outpatient Services:

☐ Emergency room ☐ Pathology report(s) ☐ Laboratory results ☐ Radiology results ☐ Rehabilitation services
☒ Other: Please see enclosed Subpoena or Letter Request for information to be disclosed.

I understand that:

- *The X-ray films released to me are the "ORIGINAL" films (the only originals available). I must return the films to St. Alexius Medical Center for a complete medical record film file.
- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient and, therefore, may not be protected by the federal privacy law regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

_____ _____ _____ _____

(Signature of patient or legal representative) (Date) (Witness signature) (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient. _____)

Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR number: _____

When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: ☐ Driver's license ☐ Picture ID ☐ Legal guardian ☐ Court appointed legal guardian ☐ Power of attorney ☐ Executor of estate

☐ Other: _____

Person/department completing the request: _____

ALEXIAN BROTHERS
St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169

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Patient Name