AMITA HEALTH®

AMITA HEALTH MEDICAL CENTERS

INSTRUCTIONS: This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

SECTION 1 - Patient Information

Patient Full Name - First, Middle, Last:		Birthdate: Month _____ Day _____ Year _____	
Patient Address - Street/Apt/Suite:	City:	State:	Zip:
Contact Phone Number:	Alternate Phone Number:	**OFFICE USE ONLY:** Patient MRN/Encounter Number	

SECTION 2 - Disclosure of Health Information

I hereby authorize and request that my health information be OBTAINED FROM the following Facility/Entity/Individual:

FROM - Name of Facility/Entity/Individual: ABBHH OUTPATIENT GROUP PRACTICE			
Street Address/Apt/Suite: 1786 MOON LAKE BLVD.	City: HOFFMAN ESTATES	State: IL	Zip: 60169
Phone Number: 847-230-3593	Fax Number: 847-230-3559		

I hereby authorize and request that my health information be DISCLOSED TO the following Facility/Entity/Individual:

TO - Name of Facility/Entity/Individual: RECORDS DEPOSITION SERVICE, INC.			
Street Address/Apt/Suite: P.O. BOX 5054	City: SOUTHFIELD	State: MI	Zip: 48086-5054
Phone Number: 248-357-3330	For Direct Patient Care Only - Fax Number:		

SECTION 3 - Purpose Of Disclosure

☑ Legal ☐ School ☐ Further Care/Treatment ☐ Transfer/Placement
☐ Insurance ☐ Personal Use ☐ Other (specify) _____

SECTION 4 - Pick Up Method

Released Via: ☑ US Mail ☐ Pick-Up ☐ Electronic Portal (Additional form may be required) ☐ CD (Imaging Only)

SECTION 5 - Medical/Surgical Health Information To Be Disclosed

Medical/Surgical Health Information To Be Disclosed - Check All That Apply

***IMPORTANT NOTE:** For inpatient, Observation, Emergency Room and Outpatient Surgery/Procedure visits, an abstract of the record will be provided, which includes Test Results, ER Record, History and Physical, Consultations, Operative Report, Discharge Summary, Face Sheet, unless otherwise specified. _____

☐ Inpatient or Observation Stay*
☐ Emergency Room Visit*
☐ Outpatient Surgery/Procedures*
☐ Radiology/X-Ray written report(s)
☐ Radiology films/digital images
☐ Laboratory Results _____
☐ Other Test Results _____
☐ Clinic Notes (specify clinic) _____
☐ Rehab or Therapy Notes (specify type) _____
☑ Other (specify) PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

SECTION 6 - Dates of Treatment

Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017): _____

Authorization for Release of Patient Health Information

Place Label Here

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SECTION 7 – Specific Consent MUST BE COMPLETED FOR ALL REQUESTS

If any of the highly confidential information listed below is contained in the medical records requested, I am specifically authorizing the use and/or disclosure of this information by checking the boxes below, if applicable to this authorization.

- ☐ Information about Mental/Behavioral Care and Treatment
- ☐ Information about Substance Abuse Care and Treatment
- ☐ Information about Psychological Testing
- ☐ Information about HIV/AIDS Testing or Treatment
- ☐ Information about Sexually Transmitted Disease(s)
- ☐ Information about Genetic Testing
- ☐ Not Applicable to this authorization

SECTION 8 – Behavioral/Substance Abuse Health Information To Be Disclosed

Behavioral/Substance Abuse Health Information To Be Disclosed– Check All That Apply

☐ Inpatient Stay: An abstract of the record will be provided, which includes Test Results, History and Physical, Psychiatric Evaluation, Consultations, Discharge Summary, Face Sheet, unless otherwise specified._____

- ☐ History & Physical Screen
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Psychological Evaluation
- ☐ Dates of Admission and Discharge
- ☐ Progress Notes
- ☐ Medication information
- ☐ Laboratory Results
- ☐ Radiology Results

Education Department

- ☐ Psychiatric Diagnosis
- ☐ Attendance/Tuition
- ☐ Medical Diagnosis
- ☐ CD Diagnosis
- ☐ Treatment Information
- ☐ Follow Up Care
- ☐ Homework Information
- ☐ IEP of 504 Plan

☐ Treatment Plan ☐ Assessment (specify type) _____

☐ Other (specify) _____

Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017): _____

SECTION 9 – Important Information

I have read and understand the following statements:

Note: If the authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the date the request is received. If this authorization is for medical/surgical or research, an expiration date is not required.

I understand that this Authorization will expire on _____/_____/_____ .

I understand that my health information may be shared with other AMITA healthcare providers for the purposes of treatment and care coordination.

I understand that I have the right of access to inspect and obtain a copy of my health Information.

I understand that I can cancel this authorization at any time by submitting a written notice to the **Health Information Management Department of the hospital where my health information is stored.** I understand that my cancellation will take effect when the Health Information Management Department receives my written notice.

I understand that my cancellation will not have any effect on health information released before the Health Information Department received my written notice.

I understand that health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

I understand that under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that failure to provide all required information on this authorization form will not constitute a proper authorization to disclose protected health information, including the refusal to sign this authorization and that, therefore, my request may not be honored.

I understand that refusal to sign this authorization will not affect any conditions of my treatment, payment, enrollment, or eligibility for benefits.

SECTION 10 – Signatures

***Patients 12-17 years of age** must sign for Behavioral Health, Substance Abuse, HIV/AIDS, STD, Pregnancy, Birth Control information.
****Legal Representative or Guardian,** please attach a court order or other documentation designating your legal status, as applicable.
*****Signature of witness** who can attest to the identity of the authorized signatory is required to release any mental health or developmental disability information. The witness cannot be the same person as the authorized signatory.

_____ ___/___/____ _____ ___/___/____
*Signature of Patient Date *** Signature of Witness Date

_____ ___/___/____ _____ ___/___/____
**Signature of Parent, Legal Representative or Legal Guardian Date Relationship of Parent, Legal Representative or Legal Guardian

Place Label Here