CentegraHealthSystem

AUTHORIZATION FOR THE RELEASE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ **MRN:** _____
Last First MI

PATIENT ADDRESS: _____
Street City State Zip

DATE OF BIRTH: _____ **TELEPHONE:** _____
(MM/DD/YYYY)

The undersigned hereby authorizes and requests:

☐ Centegra Hospital - McHenry ☐ Centegra Hospital – Woodstock ☐ Centegra Hospital – Huntley ☐ Centegra Physician Care ☐ Other: _____ * Please use the separate Behavior Health Authorization for Release of Information Form when requesting records from Centegra's Outpatient Behavior Health, Inpatient Behavior Health and Crisis Departments.	to disclose and provide the requested information to:	RECORDS DEPOSITION SERVICE, INC. Individual/Facility/Entity to be released to: PO BOX 5054 Street Address SOUTHFIELD MI 48086-5054 City State Zip 248-357-3330 Telephone number 248-357-3337 Fax number

HEALTH INFORMATION TO BE DISCLOSED:

Date(s) of Service (if known): _____

☐ Emergency Department	☐ Operative Report	☐ Immediate Care	☐ Billing Reports
☐ Hospital Abstract	☐ Radiology Report	☐ Radiology Image	■ Other (specify): _____
☐ Discharge Summary	☐ Cardiac Diagnostic Report	☐ Cardiac Image	PLEASE SEE ATTACHED SUBPOENA
☐ Medication Records	☐ Therapy (PT OT ST)	☐ Immunizations	OR LETTER REQUEST
☐ Entire Hospital Record	☐ Physician Office	☐ Lab Results	

PURPOSE FOR DISCLOSURE: ☐ Further Care ☐ Insurance Claim ☐ Legal ■ Other PRETRIAL DISCOVERY

I fully understand and acknowledge that my medical record may contain information relating to mental health, developmental disabilities, alcohol/drug abuse and/or Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) test results or other sensitive information, and I expressly authorize the release of any such information contained in records designated above. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws and regulations. Centegra Health System is not responsible for any re-disclosures of health information or medical records. As described in Centegra's Notice of Privacy Practices, I understand and acknowledge that for the purposes of third party payment to Centegra Health System that diagnostic and therapeutic information may be required to process payment and will be disclosed to my insurance company and/or the insurance company's review agency and no authorization is required for such disclosure unless I choose to pay for services in full and out-of-pocket at the time such services are rendered. I understand that this authorization is voluntary and Centegra Health System will not condition treatment, payment, enrollment or eligibility for benefits on this authorization.

I may inspect and arrange for photocopies of records/health care information that are to be disclosed. I understand that I may be responsible for costs associated with obtaining copies of my records. I may revoke this authorization at any time, except to the extent that action has been taken in good faith reliance on this authorization, by submitting a written revocation to Centegra Health System Medical Records, 527 W. South Street, Woodstock, IL 60098.

Unless otherwise revoked, this authorization will expire within one (1) year from the date of signature or ☐ end of current treatment (identify treatment): _____ ☐ Other event _____.

Patient/Representative Signature: _____ Date: _____

If a personal representative is signing this authorization, please attach document(s) of the personal representative's authority to act on behalf of the patient, if required.

Witness Signature: _____ Date: _____