Edward Hospital & Health Services

AUTHORIZATION

TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Legal Name: _____ **Date of Birth:** _____ **Telephone Number:** _____

Street Address: _____ **City, State, Zip Code** _____

***Approximate dates of treatment** (*Must be completed)

_____

I authorize the use and disclosure of the individually identifiable health information about me that is described below by the Facility below for the specific purposes listed below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below.

Specific information to be used or disclosed (check applicable box(es))

- ☐ Emergency Record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ Report of Operation
- ☐ Pathology Report
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Physical Therapy, Occupational Therapy or Speech Therapy
- ☐ Psychiatric Assessments
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Psychosocial History
- ☐ Cardiac Catherization Report
- ☐ Cardiac Diagnostic Tests
- ☐ EKG or EEG Reports
- ☐ Radiology CDs or Films
- ☐ Physician Office Medical Record
- ☐ Abstract Copy (Tests, Results, and Typed Reports)

Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

Facility using or disclosing the information (check appropriate Edward entity. If facility is not part of Edward please check and write in facility name and address on blank lines.)

- ☑ Edward Hospital
- ☐ Edward Medical Group
- ☐ Linden Oaks Hospital
- ☐ Linden Oaks Medical Group
- ☐ Facility_____ Address_____

Purpose(s) of the use or disclosure:

- ☐ Continuation of Care
- ☐ Insurance
- ☐ Personal
- ☑ Legal

Method of disclosure:

- ☑ Copy of Record –Mailed to address
- ☐ Copy of Record to be picked up
- ☐ Verbal Exchange of Information

Person(s) or organization(s) authorized to receive the information:

Name	RECORDS DEPOSITION SERVICE, INC.
Street Address	120 W. MADISON STREET, SUITE 300
City, State, Zip Code	CHICAGO, IL, 60602
Phone Number	PHONE: 312-553-8900 FAX: 312-553-8901

I understand the following:

- My decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and I may refuse to sign this form. If this authorization relates to the use or disclosure of mental health information, these are the consequences of my refusal to consent:
- My health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits may not be conditioned upon my signing this authorization.
- Unless specifically restricted or limited, the information used or disclosed may include information related to behavioral and mental health services,* sexually transmitted disease, genetic testing, evaluation and treatment for alcohol or drug abuse,* and results of HTLV-III, HIV or AIDS testing. If the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In that case, the person or organization receiving it may redisclose the information.
- I may revoke this authorization at any time by giving a written revocation to the Facility to which I presented this authorization. However, my request for revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law.
- This authorization expires on *(specify date or event)* _____. For mental health records, if no date is specified, this authorization is effective only on the date signed. For all other records, if no expiration date is specified this authorization shall be **effective for 90 days** after the date of my signing below, unless revoked by me sooner, or limited or restricted to a shorter time period by applicable law.
- I am entitled to inspect and copy any information that is used or disclosed based upon this authorization. I am also entitled to a copy of this authorization after signing below; if signing in person at the Facility, I may ask for a copy of this authorization, if one is not provided, before I leave.
- ____ If authorization is for marketing purposes and the Facility will receive compensation from a third party for use and disclosure of my information, this line will be checked.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

_____ _____

Signature of Patient or Legally Authorized Representative[+] *Date*

_____

If not Patient, then Relationship of Legally Authorized Representative to Patient

_____ _____

Signature of Witness *Date*

[+] *If the patient is 12-17 years of age and the patient's parent/legal guardian is authorizing the use and disclosure of the patient's mental health records, the signature of the minor patient is also required.*

_____ _____

Signature of minor patient *Date*

* ***Notice to Individuals Receiving Alcohol, Drug Abuse and/or Mental Health Information****: The confidentiality of alcohol and drug abuse patient records and/or mental health records disclosed to you pursuant to this authorization is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.*

FOR EDWARD STAFF ONLY COPY SENT ON:	
Date	Initials

To be Completed by Edward Staff
Medical Record #_____
Acct #_____