

# REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION



Use this form to request a copy of your medical records. In order for CCHHS to respond promptly and accurately to your Authorization, please complete this form in its entirety.

Patient Last Name		Patient First Name			Patient Middle Name		
Birth date	Month	Day	Year	Today's Date	Month	Day	Year
Address			City	State	Zip	Phone	
<b>INFORMATION REQUESTED.</b> I authorize the Cook County Health & Hospitals System to use or disclose the following information during the term of this Authorization. <b>Check all that apply.</b>							
<input type="checkbox"/> Clinic visit notes (list Clinic) _____ <input type="checkbox"/> Dental records <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Surgical (operative report, pathology report) <input type="checkbox"/> Summary, including Hospitalization (History and Physical, Consultations, Surgical, Discharge Summary)		<input type="checkbox"/> Complete Medical Record <input type="checkbox"/> Billing Records <input type="checkbox"/> X-Ray Results <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Therapy Notes (please specify) _____ <input checked="" type="checkbox"/> Other (please specify) <u>PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST</u>			<b>Radiology Images</b> <input type="checkbox"/> General <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Angiogram <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Bone Scan		
<input type="checkbox"/> Pharmacy Records							
<b>For the following dates of treatment</b>		<input type="checkbox"/> Specific date: _____			<input type="checkbox"/> All Dates		
<b>From these Facilities (Check all that apply)</b>							
<input checked="" type="checkbox"/> John H. Stroger, Jr. Hospital of Cook County <input type="checkbox"/> Oak Forest Hospital of Cook County <input type="checkbox"/> Provident Hospital of Cook County <input type="checkbox"/> Ruth M. Rothstein CORE Center		<input type="checkbox"/> Cook County Department of Public Health <input type="checkbox"/> Ambulatory & Community Health Network <input type="checkbox"/> Fantus Clinic <input type="checkbox"/> Sengstacke Clinic <input type="checkbox"/> Other: _____			<b>Cermak Health Services of Cook County</b> <input type="checkbox"/> Cook County Jail <input type="checkbox"/> Juvenile Temporary Detention Center		
<b>RECIPIENT.</b> Delivery details – to you or to the person/company (for example, insurance company, school, physician)							
<b>Delivery Method</b>				<input type="checkbox"/> Pick up in person <input type="checkbox"/> US Mail		<input checked="" type="checkbox"/> Other (please specify) email to requests@recdep.com	
Send To – Name <b>RECORDS DEPOSITION SERVICE, INC.</b>							
Address P.O. BOX 5054		City Southfield	State MI	Zip 48086-5054	Phone FAX (248) 357-3337		
<b>The purpose of the copy (disclosure) is:</b>				<input type="checkbox"/> My personal use		<input type="checkbox"/> Sharing with a healthcare provider	<input checked="" type="checkbox"/> <b>Other (please specify)</b> DISCOVERY BEFORE TRIAL
<b>TERM.</b> Unless a box below is checked, this Authorization will expire when the request is fulfilled.							
<input type="checkbox"/> From the date of this Authorization until: _____							
<input type="checkbox"/> Until the following event occurs: _____							
<input checked="" type="checkbox"/> Other (please specify): <u>ONE YEAR FROM DATE OF SIGNATURE</u>							
NOTE: For mental health records, the term must be stated, you may not use "no expiration."							



PATIENT LABEL

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**SPECIFIC CONSENT SECTION Please note if the below is not completed, this information will not be released.**

**Check any or all of the boxes below to authorize this information to be used or disclosed with your record.**

**Information about:**

- A Mental Illness or Developmental Disability
- HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative)
- Communicable Diseases
- Sexually Transmitted Infections
- Substance (i.e. alcohol or drug) Abuse
- Abuse of an Adult with a Disability
- Sexual Assault
- Child Abuse and Neglect
- Genetic Testing
- Artificial Insemination
- Psychotherapy Notes (which are not part of the official medical record)
- All of the above (By checking this box, I am indicating that I have reviewed the entire list above and authorize the use and disclosure of all related confidential information in the manner described in this Authorization.)**

I understand that I may revoke this authorization at any time by notifying CCHHS in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCHHS before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient CCHHS cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand that CCHHS may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that CCHHS will not provide such research-related treatment unless I provide this authorization.

I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize CCHHS to use or disclose my health information in the manner described in this Authorization.

Signature of Patient	Date
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**FOR PERSONAL REPRESENTATIVES OF THE PATIENT**

Name of Personal Representative	Relationship to Patient
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*I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.*

Signature of Personal Representative	Date
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PATIENT LABEL