LOYOLA MEDICINE

A Member of Trinity Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (print): _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Social Security Number (Last 4 digits) XXX-XX-__ __ __ __

The undersigned hereby authorizes and requests:

☐Loyola University Medical Center ☐Gottlieb Memorial Hospital

☐MacNeal Hospital ☐Loyola Medicine Clinic (Specify Location) _____

Director of Medical Records and/or his/her designee to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to: Records Deposition Service
Address (City/State/Zip Code): P.O. Box 5054, Southfield, MI 48086-5054
Telephone Number: (248) 357-3330 email: requests@recdep.com

Dates of treatment/service to be released: _____
Purpose for which this information is to be released:
☐ Continuity of Care ☐ Personal Use ☒ Attorney/Legal Case
☐ Disability ☐ Insurance ☐ Other (specify): _____

INFORMATION TO BE RELEASED: (Check all that apply)
☐ Abstract (Discharge Summary, Operative Report, History & Physical, Radiology Written Report, Lab Results, and Consultations, if applicable)
☐ General Medical Record (Abstract information above and i.e., orders, notes and interdisciplinary care records filed to date)
☐ Lab Results ☐ Outpatient Records ☐ Emergency Room Record ☐ Cardiac Cath Report
☐ Immunization Record ☐ Operative Report ☐ Pathology Written Report ☐ Radiology Written Report
☐ Radiology Films/Digital Images and Written Report (pick up in Radiology) ☐ Pathology Slides/Blocks (pick up in Pathology)
☐ Other (Specify): _____

MY HIGHLY CONFIDENTIAL INFORMATION: *By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.*

☐Psychiatric/mental health, mental retardation or developmental disabilities information (Parent/guardian co-signature required for the release of psychiatric information of patients 12-17 years old)

☐HIV and AIDS testing, diagnosis or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

☐Communicable disease, including sexually transmitted diseases diagnoses/lab results/treatment

☐Alcohol/drug abuse or addiction diagnosis/treatment

☐Child abuse and neglect ☐Domestic abuse by an adult ☐Sexual assault ☐Genetic testing

You must acknowledge you are checking these categories by furnishing your written signature here: _____

☐ **This authorization is valid until** _____/_____/_____

Any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given. You have the right to revoke this authorization except that such revocation will not apply in any uses and disclosures of your information that are described in the above indicated facility Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.

I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the consents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form. To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 S. First Avenue, Maywood, Illinois 60153. Include a copy of this authorization with your correspondence.

Patient/Representative Signature: _____ Date: _____

(OVER)

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State your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for this patient: _____

If the patient is unable to sign, the patient shall mark this release with an "X" and in the presence of two (2) witnesses with their dated signatures below:

Witness Signature: _____ Date _____

Witness Signature: _____ Date _____

NOTE: WE CANNOT CONDITION TREATMENT BASED ON YOUR SIGNING OF THIS AUTHORIZATION.

ATTORNEYS ONLY:
If you are an attorney making this request pursuant to a legal subpoena, discovery request or "other lawful process, in the absence of patient authorization or a court order, you must provide satisfactory assurance that the patient was provided with sufficient notice and opportunity to object to this release of protected information.

(CHECK ALL THAT APPLY)

EITHER:
☐ You have made a good faith effort (such as by sending a notice to the individual's last known address) to provide written notice to the individual who is the subject of this request, AND
☐ The notice identifies the litigation at issue with sufficient specificity to allow the individual to raise an objection, AND
☐ The time to raise an objection has passed and no objections were filed, or if filed, were resolved to allow disclosure.
OR:
☐ In lieu of notice, reasonable efforts were made to secure a "qualified protective order", AND
☐ The parties have agreed to the qualified protective order and have presented it to the court or administrative tribunal, OR
☐ The party seeking the information has requested a qualified protective order from the court or administrative tribunal.

Attach any written documentation to support the above representatives in this form.

ATTESTATION OF ATTORNEY

I hereby acknowledge that the patient/subject, or patient/subject's legal representative (patient or guardian), was provided with sufficient notice and opportunity to object to this release of protected health information and tht an objection or response has not been received. I also represent that the protected health information requested meets the "minimum necessary standard" as described in the HIPAA Privacy Rule.

Attorney Signature: _____ Date: _____
Law Office Address: _____
City/State/Zip Code: _____ Telephone Number: _____

Prohibition on Redisclosure (if applicable)
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Any mental health, substance abuse, genetic testing, HIV/AIDS, communicable disease, child abuse, domestic abuse, or sexual assault information disclosed by the facility releasing medical records pursuant to the authorization may not be further disclosed.