HCR ManorCare

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS

For HCR ManorCare Purposes: This authorization was completed by:

☐ Patient

☐ Legal Representative

☐ Oral Request by a Current Patient or His/Her Legal Representative

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1. Patient Name: _____
DOB: _____ SSN: _____

2. Disclosing Facility ("Facility"): _____

3. I am the patient listed above or the legally authorized representative of the patient listed above ("Requestor"). I authorize the Facility to release my protected health information to:
Name of Person/Physician/Organization: RECORDS DEPOSITION SERVICE, INC.
Street Address: 120 W. MADISON STREET, SUITE 300
City/State/Zip: CHICAGO, IL, 60602

4. How information should be delivered:

☐ Mailed to the above address ☐ Reviewed at Facility

☐ Picked up at Facility

5. Information requested for records created between dates ___/___/___ and ___/___/___

☐ Dietary Notes	☐ Activity Notes	☐ Nursing Notes
☐ Physician Orders	☐ Physician Progress Notes	☐ Care Plans
☐ Discharge Summary	☐ X-Ray Reports	☐ Lab Results
☐ Social Services Notes	☐ Therapy Notes	☐ Billing Records

☑ Other (Specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

6. Purpose of disclosure:

☐ At the request of the individual ☑ Legal

☐ Continuation of medical care ☐ Payment/Insurance

☐ Other (Specify) _____

7. Understandings and agreements of the Requestor:

a) I understand that I may revoke this authorization at any time by notifying the Facility in writing, but if I do, it will not affect any actions taken by the Facility prior to receiving the revocation.
b) The Facility may not place conditions on treatment, payment, enrollment or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorizations applies.
c) I understand that once the information described above is disclosed, it may subject to redisclosure by the recipient and no longer be protected by HIPAA.
d) This authorization will expire two months from the date of my signature below.

8. Print name of Requestor:_____

If you are not the patient, please select the choice that best describes your authority and **please provide** appropriate supporting documents:

☐ Health Care Power of Attorney/Directive
☐ Guardian
☐ Representative of the Estate
☐ Health Care Surrogate or Proxy. Please specify relationship:_____
☐ Next of Kin for Deceased (please sign provided addendum)
☐ Other ☐

9. Signature of Requestor:

X_____ Date:_____

If an Oral Request by a Current Patient or His/Her Legal Representative:

X_____ Date:_____
Name of HCR ManorCare Representative