Authorization for Release of Patient Health Information

INSTRUCTIONS: This authorization is made by you for the release of your healthcare information, as indicated. Please complete each section. Sections NOT completed may delay the request of information being released. If you decline to consent to the release of information, the records will not be released.

SECTION 1 - Patient Information

Name:			Date of Birth:
Address (street, city, state, zip):			
Phone Number(s): Home	Cell	Business	Social Security Number (last 4): XXX-XX-_ _ _ _

SECTION 2 - Authorized To Request Use or Disclosure (FROM)

I request that my medical record information be sent **FROM** the person(s)/location(s) indicated below.

Organization: PRESENCE HEALTH SAINT JOSEPH MEDICAL CENTER

Address (street, city, state, zip): 333 NORTH MADISON STREET, JOLIET, IL 60435

SECTION 3 - Authorized Recipient To Receive (TO)

I request that my medical record information be sent **TO** the person(s)/location(s) indicated below.
If you are requesting **access to your own medical record**, please fill in your own personal information.

Name:

Organization: RECORDS DEPOSITION SERVICE, INC.

Address (street, city, state, zip): P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

Phone Number(s): Home	Cell	Business 248-357-3330	Fax 248-357-3337

SECTION 4 - Purpose Of The Use or Disclosure (e.g. further care, insurance claim, attorney inquiry, personal use, etc.)

PRE-TRIAL DISCOVERY

SECTION 5 - Disclosure To Include

The following information is authorized for release for the **treatment dates of**:

This disclosure will include the following types of reports (check all that apply):

☐ Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests).

☐ Imaging/Radiology Report	☐ Operative Report	☐ History and Physical	☐ Pathology Report
☐ Emergency Report	☐ Consultation Report	☐ Immunization Record	☐ Itemized Bill
☐ Progress/Physician Notes	☐ Discharge Summary	☐ EKG/EEG/EMG Report	☐ Entire Chart
☐ Laboratory Report	☑ Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST		

SECTION 6 – Highly Confidential Information To Be Disclosed

The following highly confidential items must be checked off to be included in the use or disclosure of health information:

☐ HIV/AIDS related health information and/or records (the patient 12 or over must authorize this release)

☐ Behavioral or Mental Health Information and/or Records (Specify types of records under "Other" above. Note that release must be witnessed and patient 12 or over must authorize this release)

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- ☐ Information about sexuality transmitted disease (the patient 12 or over must authorize this release)
- ☐ Pregnancy (the patient 12 or over must authorize this release)
- ☐ Birth Control (the patient 12 or over must authorize this release)
- ☐ Drug/Alcohol Diagnosis, Treatment and/or Referral Information (the patient 12 or over must authorize this release)
- ☐ Genetic Testing Information and/or Records
- ☐ Information about Sexual Assault/Abuse
- ☐ Information about Child Abuse and Neglect

SECTION 7 - Authorization Expiration Date

This authorization is approved for: ☐ This occurrence only ☐ 60 days from the date of signature Date:_____

☐ 1 year from the date of signature (mental health and Presence Life Connection records only)

Date:_____ *Only effective for this occurrence if none is chosen

SECTION 8 - Please read the following statements carefully:

This authorization is voluntary. Presence Health will not condition your treatment on giving this authorization. However, Presence Health may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to Presence Health. I understand that revocation of this authorization will not affect action you took in reliance in this authorization before you received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Presence Health may use and/or disclose my PHI for a specific purpose. I understand that, if the persons or organizations I authorized above to receive and/or use the PHI described above are subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing or HIV/AIDS information disclosed by Presence Health pursuant to the authorization may not be further disclosed except pursuant to my authorization.

I have had full opportunity to read and consider the contents of this authorization and I confirm that the contents 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 to the persons and/or organizations named in this form the PHI described in this form.

I understand there may be a reasonable charge to obtain a copy of these records. I understand that I am entitled to a copy of this authorization after signing below. If this authorization includes behavioral health records, I understand that I have the right to inspect and copy the records to be disclosed.

Notice to receiving Agency/Person: *Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. 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.*

SECTION 9 - Signature

Patient Signature:	Date:
Personal Representative Name: (Print)	Personal Representative Phone #:
Personal Representative Relationship to Patient and Authority:	
Personal Representative Signature:	Date:
Witness Name (required for the release of mental health information):	Date:
Witness Signature:	Date:

SECTION 10 - Verification Of Authority

How is the person's identity, authority and relationship to the patient authorized?	☐ Personal representative status (identify as parent, guardian, executor, administrator, power-of-attorney)
☐ Personal identification	☐ Warrant, subpoena, order, summons, civil investigation or other legal process
☐ Government credentials	
☐ Authority is known	Witnessed By:

SECTION 11: Requested Format	SECTION 12: Method of Delivery
☐ Paper ☑ CD	☑ Mail ☐ Pick-up

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