Resurrection Health Care®

AUTHORIZATION
TO USE AND DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION
RESURRECTION HEALTH CARE

Patient's Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____

Telephone Number: ( ) _____

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

I understand that Resurrection Health Care may not and will not deny or condition my health care treatment or payment for services, upon my signing this authorization for the requested use and disclosure. I further understand that, 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 such a case, the information may be redisclosed by the recipient to others for other purposes. I understand that I may, at any time, inspect or obtain a copy of the information about me that will be used and disclosed as described below, by mailing a written request to the address given below or presenting it in person at the facility listed below.

Specific description of health information to be used or disclosed: _____

(*Note: if not specifically limited or restricted, the types of information to be used or disclosed may include medical, psychiatric or psychological records, records of evaluation and treatment for alcohol or drug abuse, records and results of HTLV-III, HIV or AIDS testing, etc.)*

Approximate dates of treatment: _____

Purpose of the use or disclosure: **FOR DISCOVERY BEFORE TRIAL**

(*e.g. further care, insurance claim, attorney inquiry, at the request of the individual, personal use, etc.)*

Persons or organization using or disclosing the information: _____

_____

_____

Persons or organizations receiving the information

RECORDS DEPOSITION SERVICE, INC.
120 W. MADISON ST., STE. 300
CHICAGO, IL 60602
P: 312.553.8900
F: 312.553.8901

I understand that my decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and that I may refuse to sign this form. If I do not sign this form, the information will not be disclosed. I understand that I may revoke this authorization, in writing, at any time. However, such a 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. I may make such a written revocation by mailing it to the facility address above or presenting it in person to the Medical Record Department of the facility listed above. I also understand that I may request a copy of Resurrection Health Care's Notice of Privacy Practices, or ask any other questions by calling this facility's Medical Records Department of at any time in order to learn more about how information about me is used or disclosed by Resurrection Health Care or about revocation of this authorization.

Unless revoked by me sooner or limited or restricted to a shorter time period by applicable law, this authorization shall be effective for ninety (90) days after the date of my signing below**. 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.

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 (when appropriate) *Date*

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

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such redisclosure.

White Copy to Patient Chart **Yellow Copy to Patient** RHC-225 4/03