ROSALIND FRANKLIN UNIVERSITY
Health System

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE (RELEASE) HEALTH INFORMATION
Held or Sought by Rosalind Franklin University Health System

Notice to individual: In order to protect your privacy, we will not obtain, use or release your health information unless authorized by law. We may obtain, use and release certain information upon your "authorization" if this form is completed. Even if you complete this form, you may later decide to change your mind and revoke your authorization in writing as described in the Notice of Privacy Practices (copies available upon request). We may not condition treatment, payment, enrollment or eligibility for benefits on whether this form is completed. You should know that once your health information is received by somebody else, we can no longer protect it and it is possible that the law might not prevent that other person from releasing it. Finally, we may require the payment of reasonable fees for copying records.

Whose health information is to be obtained, used or disclosed?

Last Name, First, MI

Street Address

Date of Birth

City, State, Zip code

What type of health information is being sought?
(must use different form for mental health information or alcohol/drug abuse treatment records)

☐ Entire medical record

☐ Entire billing record

☑ Only specific information as described below: (may be limited by dates and/or topics)
PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST FOR DISCLOSURE INFORMATION

Who is authorized to release the health information?

☑ Rosalind Franklin University Health System and members of its workforce

☐ Other:

Name or description of person(s) or business, etc.

Street Address

City, State, Zip code

Who is authorized to use or receive the health information?

RECORDS DEPOSITION SERVICE, INC.
Name or description of person(s) or business, etc.

120 W. MADISON ST., SUITE 300
Street Address

CHICAGO, IL, 60602
City, State, Zip code

P: 312-553-8900
F: 312-553-8901

What is the purpose for this authorization? (must use different form for research or marketing purposes)

☐ at the request of the individual ☑ other: LEGAL - FOR DISCOVERY BEFORE TRIAL

Authorization and Expiration Date

By signing this form, I authorize health information to be obtained, used and disclosed as indicated above.

Signature

Date

Expiration Date: _____

Unless indicated otherwise, the expiration date will be one year from date of signed Authorization.

I am: ☐ the individual or
☐ the personal representative of the individual and my identity is:

Last Name, First, MI

Street Address

City, State, Zip code

Telephone Number

Description of authority to act as personal representative

PLEASE MAIL OR FAX YOUR COMPLETED FORM AS FOLLOWS:
Attn: Medical Records, RFUHS, 3471 Green Bay Road, North Chicago, IL 60064 OR Fax: (847) 578-3269