

ST. BERNARD HOSPITAL

AND HEALTH CARE CENTER
328 WEST 64TH ST. CHICAGO, IL 60621
PHONE 773.962.4089 FAX 773.962.4219

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby authorize the use or disclosure of my health information by St. Bernard Hospital as described below. I understand that this authorization is voluntary. I further understand that if the organization authorized to receive this information is not a health care provider or health plan, the released information may no longer be protected by federal and state privacy regulation.

THIS REQUEST IS FOR MEDICAL RECORDS ONLY

Patient Name: _____ Date of Birth: _____
 Address: _____ Phone: (____) _____
 SS#: _____

PERSON OR ORGANIZATION RECEIVING/SENDING THE INFORMATION

From/To: RECORDS DEPOSITION SERVICE, INC.

P: 248-357-3330

F: 248-357-3337

Address: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

INFO@RECDEP.COM

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for 90 days from the date of signature. This consent is also subject to revocation by the undersigned at any time between now and the release of information by notifying St. Bernard Hospital in writing. I understand that actions taken before the receipt of the written revocation will not be affected.

Preferred Output? (CD is default)

| | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> CD | <input type="checkbox"/> Paper |
|--|--------------------------------|

IMPORTANT -- PLEASE READ: A representative will contact you regarding the copy fee for the records requested. The processing time frame for medical records request is 10-15 business days.

| | | | | | | | | | |
|--|---|---|----------------------------------|---|-------------------------------------|-------------------------------------|---|---|---|
| <p>DISCLOSURE IS LIMITED TO MEDICAL INFORMATION REGARDING ADMISSION, MEDICAL DIAGNOSIS, OR TREATMENT (check all that apply):</p> <p><input type="checkbox"/> Medical Information (specify) _____</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> X-ray Films</td> <td><input type="checkbox"/> Mammogram</td> <td><input type="checkbox"/> CT Scan</td> </tr> <tr> <td><input type="checkbox"/> Nuclear Medicine</td> <td><input type="checkbox"/> Ultrasound</td> <td><input type="checkbox"/> EEG Report</td> </tr> <tr> <td><input type="checkbox"/> Pathology Slides</td> <td><input type="checkbox"/> Pathology Report</td> <td><input type="checkbox"/> Sexually Transmitted Disease Related Information</td> </tr> </table> <p><input checked="" type="checkbox"/> Other <u>PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST</u></p> <p>The requester may use the medical records and type of information authorized only for the following purposes: _____</p> | <input type="checkbox"/> X-ray Films | <input type="checkbox"/> Mammogram | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> EEG Report | <input type="checkbox"/> Pathology Slides | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Sexually Transmitted Disease Related Information |
| <input type="checkbox"/> X-ray Films | <input type="checkbox"/> Mammogram | <input type="checkbox"/> CT Scan | | | | | | | |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> EEG Report | | | | | | | |
| <input type="checkbox"/> Pathology Slides | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Sexually Transmitted Disease Related Information | | | | | | | |

I assume full responsibility for radiology film and/or pathology slides and understand that they must be returned upon completion of review.

Please provide an abstract of my medical record for period _____ From: _____ To: _____
 * Note you will be invoiced at the allowable IL Statute rate

Please provide my entire medical record for period _____ From: _____ To: _____
 * Note you will be invoiced at the allowable IL Statute rate
 * For current Illinois Statute Copy Fee please see Illinois State Comptroller web site at www.loc.state.il.us/office/fees.cfm

Authorization to Release Protected Information

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical record.

| | | |
|-----------------------------|--|-------|
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Mental Health released | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *HIV Tests & Related Information released | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Alcohol and/or Substance Abuse released | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about _____ released | _____ |

Initial each line to confirm choices

STOP!

Please confirm that you have put a checkmark and initialed ALL the protected information categories above regardless if they are applicable or not. If form is incomplete, no protected information will be released.

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING: (check one)

- Patient named above is a minor _____ years of age
 Patient named above is unable to sign because: _____

For this reason I am signing on behalf of the patient named. Indicate relationship to patient: _____

Signature: _____ Date/Time: _____

Witness: _____ Date/Time: _____

REDISCLASURE NOTICE

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations (42 C.F.R Part 2 and 45 CFR) and HIPAA Public Law 104-191 which prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.