ST.MARGARET MERCY HEALTHCARE CENTERS
5454 HOHMAN AVE
HAMMOND, IN 46320

ST. MARGARET MERCY HEALTHCARE CENTERS
24 E JOLIET ST
DYER, IN 4631

I AUTHORIZE ST. MARGARET MERCY HEALTHCARE CENTERS TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (*PleasePrint*):______________________________

Patient Address:______________________________

Date of Birth:______________ Last 4 Digits of Social Security #____________ Patient Telephone #:______________

Covering the period(s) of treatment:______________________________

INFORMATION TO BE RELEASED:

________Discharge Summary
________History & Physical
________Operative Report
________Complete Health Record
________Radiology (X-ray, CT Scan, MRI)
________EKG
________Consultations
[✓] Other (specify): PLEASE SEE SUBPOENA OR LETTER REQUEST
________ER record
________Lab Results
________UB04

INFORMATION TO BE RELEASED TO:

Name: RECORDS DEPOSITION SERVICE, INC.

Address: 120 W. MADISON STREET, SUITE 300

City, State, Zip: CHICAGO, IL 60602

Telephone #: PHONE: 312-553-8900 FAX: 312-553-8901

PURPOSE OF DISCLOSURE: _____Continuation of Care _____Insurance [✓] Attorney _____Personal Use _______Other

I understand this authorization can be revoked by me at any time in writing to (*facility Name)* except that disclosure made in good faith has already occurred in reliance on this authorization. *(facility name)* will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:______________ ______________________. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you on electronic media that meets the HIPAA and HITECH requirements, you must initial here:______________. The password for accessing your electronic media is:______________________.

I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here:**________________.

SIGNATURE:______________________________ DATE:______________

RELATIONSHIP TO PATIENT, if other than patient:______________________________

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable):______________________________

WITNESS SIGNATURE:______________________________ DATE:______________

Sisters of St. Francis Health Services

SAINT MARGARET MERCY

Place Patient Label

SMMHC Release of Information Authorization

B.ROI.0006 Rev 7/10

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