VAN MATRE
HEALTHSOUTH Rehabilitation Hospital
A ROCKFORD HEALTH SYSTEM - HEALTHSOUTH Partnership

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Protected Health Information)

I hereby authorize _____ to release the following protected health information from the medical record of:

Patient Name: _____ MRN #: _____

Address: _____

Phone #: _____ Date of Birth: _____ SS# _____

Covering the period(s) of hospitalization from:
I/P Date(s) of Admission: _____ I/P Date(s) of Discharge: _____
O/P Date(s) of Admission _____ O/P Date(s) of Discharge: _____

Information To Be Released To: RECORDS DEPOSITION SERVICE, INC.
Address: 120 W. MADISON STREET, STE. 300, CHICAGO, IL 60602 Phone #: P: 312-553-8900
F: 312-553-8901

THE PROTECTED HEALTH INFORMATION REQUESTED IS AS FOLLOWS:

_____ Discharge Summary	____ Operative Reports	____ Laboratory Reports	____ Progress Notes
_____ History and Physical	____ Physician Orders	____ Pathology Reports	____ Final Diagnosis
_____ Consultation Reports	____ Radiology Reports	____ EKG, EEG, EMG Reports	X Other

Describe Other: Please see enclosed Subpoena or Letter Request for information to be disclosed.

Purpose of Disclosure: For Discovery Before Trial

I hereby also consent to the release of the following information, which may have specific statutory protection:
I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations for specific issues including, but not limited to the following: HIV/AIDS, mental health, alcohol and substance abuse, minors, fees, industrial accidents, disability, birth defects, cancer and genetic information.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
I, on behalf of myself or any other person who may have an interest in the matter, hereby release the facility, its employees, officers, and attending physician from legal responsibility or liability in regard to the acts that I have hereby authorized.

A parent or court appointed guardian must sign for a minor child. Minors ages 12-17 years old. **(Patient, parent, legal guardian and a witness must sign and date. (Illinois Mental Health & Developmental Disabilities Confidentiality Act – Chapter 91.5, Section 803) *Federal Regulation 42CFR: Minors 12-17 yrs old may authorize the release of alcohol and/or drug abuse info.**

An adult patient must sign for him or herself, unless a legal guardian has been appointed by a court of law (legal representative in certain circumstances) or a HealthCare Surrogate has been appointed should the patient lack decisional making capacity. If patient is unable to sign a full signature, he or she must make a mark (X) and have the signatures of two witnesses.

I understand that this authorization will expire in three months on _____.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before receiving the revocation.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Relationship Date

_____ _____
Signature of Witness Date Signature of Witness Date