REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

Use this form to request a copy of your medical records. In order for CCHHS to respond promptly and accurately to your Authorization, please complete this form in its entirety.

Patient Last Name	Patient First Name	Patient Middle Name

Birth date Month	Day	Year	Today's Date Month	Day	Year

Address	City	State	Zip	Phone

INFORMATION REQUESTED. I authorize the Cook County Health & Hospitals System to use or disclose the following information during the term of this Authorization. **Check all that apply.**

- ☐ Clinic visit notes (list Clinic) _____
- ☐ Dental records
- ☐ Emergency Room Report
- ☐ Surgical (operative report, pathology report)
- ☐ Summary, including Hospitalization (History and Physical, Consultations, Surgical, Discharge Summary)
- ☐ Complete Medical Record
- ☐ Billing Records
- ☐ X-Ray Results
- ☐ Laboratory Results
- ☐ Therapy Notes (please specify) _____
- ☑ Other (please specify) PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

Radiology Images
- ☐ General
- ☐ CT
- ☐ MRI
- ☐ Ultrasound
- ☐ Angiogram
- ☐ Nuclear Medicine
- ☐ Bone Scan

☐ Pharmacy Records

For the following dates of treatment ☐ Specific date: _____ ☐ All Dates

From these Facilities (Check all that apply)

- ☐ John H. Stroger, Jr. Hospital of Cook County
- ☑ Oak Forest Hospital of Cook County
- ☐ Provident Hospital of Cook County
- ☐ Ruth M. Rothstein CORE Center
- ☐ Cook County Department of Public Health
- ☐ Ambulatory & Community Health Network
- ☐ Fantus Clinic
- ☐ Sengstacke Clinic
- ☐ Other: _____

Cermak Health Services of Cook County
- ☐ Cook County Jail
- ☐ Juvenile Temporary Detention Center

RECIPIENT. Delivery details – to you or to the person/company (for example, insurance company, school, physician)

Delivery Method ☐ Pick up in person ☑ US Mail ☐ Other (please specify)

Send To – Name
RECORDS DEPOSITION SERVICE, INC.

Address	City	State	Zip	
PO BOX 5054	SOUTHFIELD	MI	48086-5054	P: 248-357-3330 F: 248-357-3337

The purpose of the copy (disclosure) is: ☐ My personal use ☐ Sharing with a healthcare provider ☑ **Other (please specify)** DISCOVERY BEFORE TRIAL

TERM. Unless a box below is checked, this Authorization will expire when the request is fulfilled.
- ☐ From the date of this Authorization until: _____
- ☐ Until the following event occurs: _____
- ☑ Other (please specify): ONE YEAR FROM DATE OF SIGNATURE

NOTE: For mental health records, the term must be stated, you may not use "no expiration."

PATIENT LABEL

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Patient Last Name	Patient First Name	Patient Middle Name

SPECIFIC CONSENT SECTION Please note if the below is not completed, this information will not be released.

Check any or all of the boxes below to authorize this information to be used or disclosed with your record.

Information about:

- ❑ A Mental Illness or Developmental Disability
- ❑ HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative)
- ❑ Communicable Diseases
- ❑ Sexually Transmitted Infections
- ❑ Substance (i.e. alcohol or drug) Abuse
- ❑ Abuse of an Adult with a Disability
- ❑ Sexual Assault
- ❑ Child Abuse and Neglect
- ❑ Genetic Testing
- ❑ Artificial Insemination

❑ Psychotherapy Notes (which are not part of the official medical record)

❑ **All of the above (By checking this box, I am indicating that I have reviewed the entire list above and authorize the use and disclosure of all related confidential information in the manner described in this Authorization.)**

I understand that I may revoke this authorization at any time by notifying CCHHS in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCHHS before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient CCHHS cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand that CCHHS may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that CCHHS will not provide such research-related treatment unless I provide this authorization.

I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize CCHHS to use or disclose my health information in the manner described in this Authorization.

Signature of Patient	**Date**
FOR PERSONAL REPRESENTATIVES OF THE PATIENT	
Name of Personal Representative	**Relationship to Patient**
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.	
Signature of Personal Representative	**Date**

PATIENT LABEL