Adventist
Midwest Health
A Member of Adventist Health System

Authorization for Access, Use and/or Disclosure of Protected Health Information

Patient Name:			Medical Record#:
Patient Address:			
Street	Apt #	Phone #	Date of Birth / /
City	State	Zip Code	Today's Date / /

1. **I hereby request that** ADVENTIST LMH **(enter name of Adventist Midwest Health entity providing access or disclosure).**
   - ☐ **Allow me access to the information requested below**
   - ☐ **Provide me with my own copy of the information requested below (circle format you would like: photocopy, electronic, other: _____)**
   - ☒ **Disclose the information requested below to the individual or entity listed in item #3**

2. **Reason for request:** FOR DISCOVERY BEFORE TRIAL

3. **Disclose the information to the following individual or organization:**
   Name: RECORDS DEPOSITION SERVICE, INC.
   Address: 120 W. MADISON STREET, STE. 300 City: CHICAGO State: IL
   Zip Code: 60602 Phone #: 312-553-8900 Fax #: 312-553-8901

4. **Specific description of information to be accessed and/or disclosed:**
   - ☒ **My medical records**
     - ☒ Complete medical record (except for mental health and/or developmental disability, substance abuse, and/or HIV/AIDS-related information; must be checked separately)
     - ☐ Abstract (face sheet, history and physical, operative report, discharge summary, consults)
     - ☐ Surgical (operative report, pathology report)
     - ☐ Tests results (lab, radiology, cardiology, neurophysiology, respiratory)
     - ☒ Mental health and developmental disability records if applicable
     - ☒ Substance abuse records if applicable
     - ☒ HIV/AIDS-related information records if applicable
     - ☐ Therapy note: Physical, Occupational, Speech, and/or Respiratory Therapy
     - ☐ Other: _____
   - ☐ **My billing records**
   - ☐ **Any other personally identifiable information used by Adventist Midwest Health to make medical decisions about me.**
     Please describe: _____

5. **Request access and/or disclosure of records for the following dates of service:**

_____

IHRLSINFO

Place Label Here

I have read and understand the following statements:

I understand this Authorization will expire on (/ /) or when the following event occurs:

_____

Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the current day.

Note: If this authorization is for research, an expiration date is not required.

I understand that Adventist Midwest Health may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, Adventist Midwest Health will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Adventist Midwest Health will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

I understand that I may revoke this Authorization at any time by notifying Adventist Midwest Health in writing, but if I do, it will not have any affect on any actions Adventist Midwest Health took before it received the revocation.

I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.

I understand requests may be subject to a copying fee.

I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by Adventist Midwest Health.

If this Authorization Form authorizes use and/or disclosure of psychotherapy notes it may not be used to authorize the use and/or disclosure of any other protected health information.

_____ _____/_____/_____

Printed Name of Patient **Date**

_____ _____/_____/_____

Patient (or *Legal Representative) Signature **Date**

_____ _____/_____/_____

Witness **Date**

Please attach court order or other documentation designating the legal representative, as applicable.

Note to the recipient of alcohol or drug abuse records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.