Patient Name_____ Phone Number_____ Medical Record Number_____

Address_____ Date of Birth_____

## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

**FROM:** Person/Institution_____

Address_____

City_____ State_____ Zip_____

**TO: (Recipient)** Person/Institution RECORDS DEPOSITION SERVICE, INC.

Address P.O. BOX 5054 P: 248-357-3330 F: 248-357-3337

City SOUTHFIELD State MI Zip 48086-5054

Purpose or need for information:_____

Disclosure will include: (*check all that apply*)

| | | | | |
|---|---|---|---|---|
| ☐ Face Sheet | ☐ History & Physical | ☐ Laboratory Report | ☐ Operative Report | ☐ Itemized Bill |
| ☐ Discharge Summary | ☐ Progress/Physician Notes | ☐ X-ray/Radiology Report | ☐ Pathology Report | ☑ Other PLEASE SEE ATTACHED |
| ☐ Emergency Report | ☐ Nurses Notes | ☐ EKG/EMG/EEG Report | ☐ Consultation Report | SUBPOENA OR LETTER REQUEST |

Records for the period (dates) from _____ to_____

**I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:**

_____**Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse**

_____**Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment**

_____**Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing**. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian/Personal Representative (Required if Patient is not legally authorized to sign Authorization) Relationship to Patient

_____

Witness

**REDISCLOSURE:** Notice is hereby given to the patient or legal representative signing this Authorization that Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

*005013*

Advocate Health Care®

**AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION**

Patient Name:_____
MR Number:_____
Patient Number: _____
OR
Affix Patient Label

00-5013 03/07

White - Original in the Medical Record Yellow - Copy to the Patient

Patient Name_____ Date of Birth_____

Address_____ Medical Record Number_____

Phone Number_____

**AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION (evaluation, diagnosis, testing and /or treatment for alcohol and/or drug abuse [federally assisted programs], HIV or AIDS and mental health).**

I hereby authorize that such health information regarding the above-named person be forwarded:

**FROM:** Person/Institution_____

Address_____

City_____ State_____ Zip_____

**TO: (Recipient)** Person/Institution RECORDS DEPOSITION SERVICE, INC.

Address P.O. BOX 5054 P: 248-357-3330 F: 248-357-3337

City SOUTHFIELD State MI Zip 48086-5054

Purpose or need for information:_____

Disclosure will include the following verbal or written information: (*check all that apply*)

- ☐Face Sheet
- ☐History & Physical
- ☐Laboratory/Diagnostic Testing Results
- ☐School Information
- ☐Discharge Summary
- ☐Medication Records
- ☐ Behavior Health/Psychological Consult
- ☐Psychological Evaluation/Testing Results
- ☐ER Record Report
- ☐Psychiatric Evaluation
- ☐Psychosocial Assessment
- ☐Summary of Treatment Records and contact dates
- ☐Substance Abuse Treatment Record
- ☐HIV Test Results
- ☑Other PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

Records for the period (dates) from _____ to _____

I have a right to inspect and copy the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

**EXPIRATION DATE**: This release is valid for one (1) year from the date signed unless I fill in an early date _____/_____/_____.

_____ _____

**Signature of Patient** **Date**

OR

_____ _____

**Signature of Parent/Guardian/Legal Representative** **Date**

_____

**Relationship to the Patient** (See Back of Form)

_____ _____

**Witness** **Date**

**REDISCLOSURE PROHIBITED:** Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.

Advocate Health Care

**AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION**

Patient Label

00-5019 09/09

White - Original in the Medical Record Yellow - Copy to the Patient