AdvocateAuroraHealth

MRN ______________________

1) **PATIENT INFORMATION:**

Name ______ Address ______ City ______ State ______ Zip ______

Date of Birth ______ Daytime Phone (____) ______ Previous Name ______

2) **AUTHORIZES:**

Name of Health Care Provider/Plan/Other Address ______

3) **TO DISCLOSE TO:**

☐ Myself *(select delivery option below)*

☐ LiveWell/MyAdvocate Aurora portal ☐ View on Site

☐ Mail to my address above ☐ Pick up

If Mail or Pick up:

☐ Paper or ☒ Electronic format: REQUESTS@RECDEP.COM

☐ If to be picked up by another, I hereby authorize ______ to pick up my records. *(Photo ID required.)*

☒ Send to third party: RECORDS DEPOSITION SERVICE, INC.

Attn: ______

Address: PO BOX 5054

SOUTHFIELD, MI 48086-5054 *or*

Fax: 248.357.3337

Third Party Phone #: 248.357.3330

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL** (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From ______ (month/year) to ______ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

6) **INFORMATION TO BE DISCLOSED:** ☐ All record types for time frame (unless excluded, see #7)

☐ **Hospital Summary** (See #6 on back side)

☐ **Consult**

☐ **Lab Reports**

☐ **Emergency Department**

☐ **Reports Visit/Progress Notes**

☐ **Imaging Results**

☐ **Imaging Films (x-ray)**

☐ **Procedure Op Reports**

☐ **Billing Records**

☐ **Estimate** PLEASE SEE ENCLOSED SUBPOENA

☒ **Other** OR REQUEST FOR INFORMATION

Behavioral Health

☐ **Treatment Records –** Treatment Plan & Notes, Assessment, Psychiatric/ Psychologic Eval, Labs, Medications

☐ **Psychologic Test Results**

☐ **Legal Status/Court Records**

7) I understand that the information to be disclosed may include information regarding genetic testing, mental illness/developmental disabilities, Substance Use Disorder, HIV Test results, and AIDS/AIDS related illness. We will release this information, unless you indicate which information should be excluded below.

☐ Substance Use Disorder ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

☐ Genetic Testing ☐ AIDS/AIDS related illness

8) **EXPIRATION:** This Authorization is good for: *circle one* 1 month 6 months 1 year Other date or event ______
If this item is left blank, the authorization will expire in one year from the date signed. **IL Only:** Mental health/developmental disability records, information may be released only on the day the authorization is received.

9) **PURPOSE** (Check all that apply - **copy fees may apply)**

☐ Further Medical Care - **no fee** ☐ Insurance Eligibility/Benefits - **fee $**______ ☒ Legal Investigation /Action – **fee $**______

☐ Personal (at my request) - **possible fee $**______ ☐ Forms Completion - **possible fee $** ______ ☐ Other: ______ *(specify)*

10) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** I understand that I do not need to sign this Authorization to receive treatment. I am aware that I may revoke this Authorization by notifying the health information department in writing. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

11) **SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE** ______ **DATE** ______

If signed by a person other than the patient, state your relationship to the patient:

______

IL only – Witness signature for mental health/developmental disabilities records only: ______

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
(HIM/ROI Authorization)