REQUEST FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

TO: Alden- Long Grove Rehabilitation & Healthcare Center

I am requesting medical record information on:

Resident Name	Social Security Number	Date of Birth

CHECK ONE: ___ I will review the records at the facility.
___ I will pick up a copy of the record.
☑ I request that a copy of the records be sent to:

RECORDS DEPOSITION SERVICE, INC. PH: (312) 553-8900 FAX: (312) 553-8901
120 W. MADISON STREET, SUITE 300, CHICAGO, IL 60602

Information Requested (please initial)

Records covering the period from __/__/__ to __/__/__

____Dietary Notes ___Activity Notes ___Nursing Notes ___Physician Orders

___Physician Progress Notes ___Care Plans ___Discharge Summary

___X-Ray Reports ____Lab Results ___Other_____

☑Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

HIV/AIDS information may be disclosed, if any: ____yes ____no.

This request may include records of treatment of mental illness and/or use of psychotropic medication, to be sent to a third party. ____yes _____no.

The purpose for which the records will be used: FOR DISCOVERY BEFORE TRIAL

(further care, insurance claim, legal counsel, etc.)

I am legally authorized to make this request.

I am (CHECK ONE): _____ the Resident
_____ the court-appointed legal guardian-**
_____ the Power of Attorney for Health Care Agent-**
_____ the Health Care Surrogate-**
_____ the Executor or Administrator of the resident's estate-**

****Documentation is attached.**

I understand and agree to the following:

1. This authorization is voluntary.
2. This authorization will expire _____days from the date of my signature below.
3. I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I waive all claims against the facility for the release of the requested information.
5. Once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearing house, or a business associate that has a contract with the facility.
6. If I wish to have copies made, then the facility may assess a fee for copying the records. The facility will notify of the total amount due for copying and shipping.
7. The facility will only send out the requested information once it has received payment in full for the charges.

Signature:_____ **Date:**_____

Print Name:_____ _____

Contact Phone #

Witness signature:_____

(for mental health records)