Dreyer Medical Clinic
Advocate

Medical Records Department
1870 West Galena Boulevard
Aurora, Illinois 60506
Phone: 630-859-7266
Fax: 630-906-5902

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name_____

Street Address_____

City, State, and Zip Code_____

Phone Number_____

Date of Birth_____

Medical Record Number_____

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

From: Person/Organization **DREYER MEDICAL CLINIC**

Address **1870 W. GALENA BOULEVARD**

City **AURORA** State **IL** Zip **60506**

To: (Recipient) Person/Organization **RECORDS DEPOSITION SERVICE, INC.**

Address **120 W. MADISON STREET, STE. 300,**

City **CHICAGO** State **IL** Zip **60602**

Purpose or Need for Information: **FOR DISCOVERY BEFORE TRIAL**

Disclosure will include (check all that apply):

____ Face Sheet	____ History & Physical	____ Laboratory Report
____ Operative Report	____ Discharge Summary	____ Progress/Physician Notes
____ X-ray/Radiology Report	____ Pathology Report	____ Emergency Report
____ Nurses Notes	____ EKG/EMG/EEG Report	____ Consultation Report

__X__ Other: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**

Records for the period (dates) from _____ to _____

(continued on reverse)

I understand that 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 following three items, 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 the action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in one 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 organization named above will not release my health information. The above named person/organization 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 **Relationship to Patient**

_____

Witness

Re-disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Dreyer Medical Clinic and Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

Please tell us why you are requesting your health information by checking one of the following:

_____I am remaining a Dreyer patient, but seeking care from an outside physician.

_____I am moving out of Dreyer's service area.

_____My new insurance does not include Dreyer (please supply name)_____

_____I was dissatisfied with some aspect of Dreyer (please describe)_____

_____

X Other reason (please explain) **FOR DISCOVERY BEFORE TRIAL**

(1-Original to Medical Record; 2-Copy to Patient; 3-Copy to Marketing)