

Edward/Elmhurst Healthcare

AUTHORIZATION

TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____ **Date of Birth:** _____ **Social Security Number:** _____

Patient Address: _____ **Telephone Number:** _____

I authorize the use and disclosure of the individually identifiable health information about me that is described below by the Facility below for the specific purposes listed below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below.

Specific information to be used or disclosed (check applicable box(es))

- | | |
|---|--|
| <input type="checkbox"/> Emergency Record | <input type="checkbox"/> Psychiatric Assessments |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Psychosocial History |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Cardiac Catherization Report |
| <input type="checkbox"/> Report of Operation | <input type="checkbox"/> Cardiac Diagnostic Testing |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> EKG/EEG Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Physical Therapy, Occupational Therapy or Speech Therapy | <input type="checkbox"/> Radiology Images (film or CD) |
| | <input type="checkbox"/> Physician Office Medical Record |

Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Approximate dates of treatment

Facility using or disclosing the information (check appropriate Edward entity. If facility is not part of Edward or Elmhurst please check and write in facility name and address on blank lines.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Edward Hospital | <input type="checkbox"/> Edward Cardiovascular Institute (ECI) | <input checked="" type="checkbox"/> Facility _____ |
| <input type="checkbox"/> Linden Oaks Hospital | <input type="checkbox"/> Edward Home Care | Address _____ |
| <input type="checkbox"/> Edward/Elmhurst Medical Group | <input type="checkbox"/> Linden Oaks Medical Group | _____ |

Purpose(s) of the use or disclosure:

- | | |
|---|---|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance | <input checked="" type="checkbox"/> Other (describe): |
| <input type="checkbox"/> Legal | <input type="checkbox"/> PRE TRIAL DISCOVERY |

Method of disclosure:

- | |
|---|
| <input type="checkbox"/> Verbal Exchange of Information |
| <input type="checkbox"/> Copy of Record |

Person(s) or organization(s) authorized to receive the information:

Name RECORDS DEPOSITION SERVICE, INC.
Address or Fax Number PO BOX 5054, SOUTHFIELD, MI, 48086-5054
Phone Number 248-357-3330

I understand the following:

- My decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and I may refuse to sign this form. If this authorization relates to the use or disclosure of mental health information, these are the consequences of my refusal to consent:
_____.
- My health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits may not be conditioned upon my signing this authorization.
- Unless specifically restricted or limited, the information used or disclosed may include information related to behavioral and mental health services,* sexually transmitted disease, genetic testing, evaluation and treatment for alcohol or drug abuse,* and results of HTLV-III, HIV or AIDS testing. If the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In that case, the person or organization receiving it may redisclose the information.
- I may revoke this authorization at any time by giving a written revocation to the Facility to which I presented this authorization. However, my request for revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law.
- This authorization expires on *(specify date or event)* _____. For mental health records, if no date is specified, this authorization is effective only on the date signed. For all other records, if no expiration date is specified this authorization shall be **effective for 90 days** after the date of my signing below, unless revoked by me sooner, or limited or restricted to a shorter time period by applicable law.
- I am entitled to inspect and copy any information that is used or disclosed based upon this authorization. I am also entitled to a copy of this authorization after signing below; if signing in person at the Facility, I may ask for a copy of this authorization, if one is not provided, before I leave.
- ___ If authorization is for marketing purposes and the Facility will receive compensation from a third party for use and disclosure of my information, this line will be checked.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

Signature of Patient or Legally Authorized Representative⁺ _____
Date

If not Patient, then Relationship of Legally Authorized Representative to Patient

Signature of Witness _____
Date

⁺ *If the patient is 12-17 years of age and the patient's parent/legal guardian is authorizing the use and disclosure of the patient's mental health records, the signature of the minor patient is also required.*

Signature of minor patient _____
Date

*** Notice to Individuals Receiving Alcohol, Drug Abuse and/or Mental Health Information:** *The confidentiality of alcohol and drug abuse patient records and/or mental health records disclosed to you pursuant to this authorization is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.*

FOR EDWARD STAFF ONLY COPY SENT ON:	
_____ Date	_____ Initials