Healthy Driven
Edward-Elmhurst HEALTH

Office Use Only:
___ Disclosure Directive
___ Medical Record Release
MR#:_____

600600

Authorization to Use or Disclose Protected Health Information (PHI)

Elmhurst Memorial Hospital Medical Records/
Physician Practice Division Release of Information
155 E. Brush Hill Road, Elmhurst, IL 60126
331.221.6755 (office) 331.221.3726 (fax)

Physician Practice Division Patient Forms
1200 S. York Road, Suite 2000, Elmhurst, IL 60126
331.221.9076 (office) 331.221.2701 (fax)

Written authorization from the patient or legal representative is required. All sections must be completed to be considered valid.

1: Patient Information	
Name (Last, First, MI)	Birth Date
Address (Street, City, State, Zip)	Phone Number

2: Authorized to Release (FROM): I authorize the release of my PHI from the entity identified below.	
Name of Person/Facility/Agency	
Address (Street, City, State, Zip)	Phone Number Fax Number

3: Authorized to Receive (TO): I authorize the entity identified below to receive my PHI.	
Name of Person/Facility/Agency RECORDS DEPOSITION SERVICE, INC.	
Address (Street, City, State, Zip) PO BOX 5054 SOUTHFIELD, MI, 48086-5054	Phone Number 248-357-3330 Fax Number 248-357-3337

4: The PHI will be disclosed as identified below.

☐ Picked up by patient or their Legal representative	☐ Mailed to the address listed in section 3 above
☐ Faxed* (in emergency for continuum of care) to (_____) _____-_____	☐ Electronic format (select below): ☐ CD ☐Other:_____
*Note: Our policy does not allow for direct faxing to a patient	☐ Reviewed by the patient with a Staff Member Present

☐ Disclosed verbally with person specified in section 3 above. Relationship:_____
☐ Other (please specify):

5: Purpose for Release/Disclosure

☐ Personal Copy	☐ Disability	☐ Application for Insurance	☐ Insurance Claim	☐ Verbal Disclosure
☐ Form Completion	☐ Legal	☐ Continuation of Care	■ Other: PRE TRIAL DISCOVERY	

6: PHI Requested

Date(s) of Service or Hospitalization:

Provider or Practice Name (if applicable):

__Complete Chart/All Medical Records __Office Encounter (Entire Visit) __After Visit Summary
__Billing Statement __Consultation __Discharge Summary __EKG/Echo Report __ER Report
__History & Physical __Immunizations __Lab Report __Medication List __Operative Report
__Patient Plan __Problem List __Progress Note (Inpatient Only)
__Radiology Report (specify):_____ __Radiology Films/Images (specify):_____
__Photograph/Video (specify):_____ __PHI Pertaining to Form Completion
■ Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

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Patient Name:_____

Birth Date:_____

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7: Special/Sensitive PHI

I understand that the information to be released may include information relating to the diagnosis and/or treatment of sexually transmitted disease (STD), genetic testing, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), HTLV-III, mental and/or behavioral health, evaluation and treatment for drug and/or alcohol abuse. Please exclude the following sensitive information:

8: Expiration

This authorization will expire one year from this date of authorization unless an expiration date is noted here _____/_____/_____ or a written notice to revoke it is received.

9: Please read the following statements carefully.

- I understand that I have a right to inspect and/or receive a copy of the PHI to be released and also receive a copy of this authorization form.
- I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing to the Health Information Management Department, 1200 S. York Road, Elmhurst, IL 60126. I understand that the revocation will not apply to information that has already been released.
- I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.
- 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 understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy confidentiality rules.

10. Fees for Patient Requests

By signing this authorization form, I understand that Elmhurst Memorial Healthcare will charge a fee, as permitted by law, for:

- disclosing copies of the requested PHI/medical record, when released directly to the patient. If copies are sent directly to another care provider, no fee will apply. Current charges are: ● Pages 1-10 = $.50/page ● Pages 11+ = $.15/page
- medical form completion. Current charge is $20 (per calendar year/diagnosis) whether released to patient or another party.

11: Signature

Signature of Patient or Legal Representative	Date
Printed Name of Above Signee (if other than patient)	
Relationship to Patient (if other than patient) ☐ Spouse ☐ Parent ☐ Power of Attorney ☐ Other:	
Witness Signature	Date

FOR OFFICE USE ONLY - Verification of Authority

☐ Driver's license ☐ State ID ☐ Passport ☐ Government credentials	☐ Legal Representative (identity of parent, guardian, executor, administrator, power of attorney, surrogate) _____	☐ Warrant, subpoena, protective order, summons, affidavit, or other legal process, _____

Medical record #_____ Records released on _____/_____/_____ Entered into EHR: ___yes ___no

Acct #_____ Completed by_____ Date _____/_____/_____

Additional Comments: