Patient Name

DOB:

MR #

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SwedishAmerican – A Division of UW Health
(University of Wisconsin Hospitals and Clinics Authority)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. PATIENT INFORMATION: Please print clearly. All information must be provided.

Full Legal Name: _____
(First) *(Last)* *(Middle Initial)*

Current Address: _____
(Street) *(City)* *(Zip)*

Telephone Number: _____ Date of Birth: _____

2. I HEREBY AUTHORIZE AND REQUEST (Please check only one location per authorization):

☐ SwedishAmerican Hospital
☐ SwedishAmerican Medical Center-Belvidere
☐ SwedishAmerican Home Care
☐ SwedishAmerican Medical Group (SAMG):
(specify clinic location) _____
☐ Other (Name of facility/person and address):
_____
_____

3. TO RELEASE, USE AND/OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:

☐ Abstract of above only (includes dictated reports and diagnostic test results such as lab results and x-ray reports)
☐ Entire medical record (includes abstract and nursing notes, progress notes, physician orders, etc.)
☐ Medical imaging (Radiology) films (x-rays, CT, MRI, ultrasound, cardiovascular, etc.)
☑ Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

RELATING TO THE FOLLOWING TREATMENT OR TIME PERIOD:
From _____ (date) to _____ (date)

4. THE INFORMATION MAY BE RELEASED TO:

(Name of facility/person and address)
RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054

5. THE PURPOSE(S) OR NEED FOR THIS DISCLOSURE IS:

☐ Medical Care ☐ Insurance Purposes ☐ At the request of the patient
☑ Other: LEGAL - FOR DISCOVERY BEFORE TRIAL

6. FORMAT: Please check only one box. If format is not selected, records will be in paper format.

☐ Paper
☑ Secure electronic access (Internet access and valid email address required)
Email address: REQUESTS@RECDEP.COM
Select a PIN: _____
(up to 10 digits – if not chosen, date of birth will be used)

7. EXPIRATION: This authorization will expire one year from date of authorization, unless otherwise revoked by patient.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

8. FOR CLINIC USE ONLY:

If transfer is due to patient discontinuing services of physician/clinic:

☐ Insurance Requirement ☐ Physician Availability

☐ Dissatisfaction ☐ Relocation ☐ Other _____

9. PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I may revoke this Authorization in writing at any time except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, SwedishAmerican Health System, and 1401 East State Street, Rockford, Illinois, 61104

I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.

I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information.

I understand that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

I understand that I may refuse to sign this Authorization and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

Signature of Patient or Legal Representative	Relationship to Patient	Date

(Patients ages 12-17 may be required to sign and date with co-signature of parent/legal guardian)

Co-Signature	Relationship to Patient	Date

Signature of Witness	Date