Gottlieb Memorial Hospital

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (Print): ______________________ Date of Birth: ______________
Telephone Number: ______________________ Social Security Number (Last 4 digits) XXX-XX-_ _ _ _
Address: ______________________ City, State, Zip Code: ______________________

The undersigned hereby authorizes and requests:

☐ Loyola University Medical Center, Director of Medical Records and/or her designee
☐ Gottlieb Memorial Hospital, Director of Medical Records and/or her designee
☐ Other: ______________________ (Hospital/Physician/Nursing Home/Clinic)

to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to: RECORDS DEPOSITION SERVICE, INC.
Address (City/State/Zip Code): 120 W. MADISON ST. SUITE 300, CHICAGO, IL 60602
Telephone Number: (312) 553-8900

Dates of treatment/service to be released: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST
Purpose for which this information is to be released: LEGAL - FOR DISCOVERY BEFORE TRIAL

INFORMATION TO BE RELEASED (Check all that apply)

☐ Lab results ☐ Outpatient records ☐ Emergency Room Record
☐ Cardiac Cath report ☐ Immunization Record ☐ Pathology written report
☐ Radiology written report ☐ Operative Report ☐ Pathology slides/blocks (pick up in Pathology Dept)
☐ Radiology films/digital images and written report (pick up in Radiology Dept)
☐ Abstract (Discharge Summary, Operative Reports, History & Physical, X-ray/Radiology written report, Lab results, Consultations if applicable)
☐ General Medical Record (Abstract information above and i.e.: orders, notes and interdisciplinary care records filed to date)
☑ Other (Specify): PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

SECTION A: If your health information contains *any of the following*, please check all categories that apply in order to avoid delay. By checking any of these categories, you are authorizing the release of the following information:

☐ Psychiatric/mental health or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)
☐ AIDS/related illness, diagnosis/treatment ☐ HIV test results ☐ Genetic testing ☐ Alcohol/drug abuse diagnosis/treatment

You must acknowledge that you are checking these categories by furnishing your written signature here: ______________

SECTION B: This authorization is valid until ___/___/___ (You must specify the month, date and year or we cannot process this request). However, any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given. You have the right to revoke this authorization except that such revocation will not apply to any uses and disclosures of your information that are described in the LUHS or GMH Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.

I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form.

To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 S. First Avenue, Maywood, Illinois, 60153. Include a copy of this authorization with your correspondence.

Patient/Representative Signature: ______________________ **Date:** ______________
State your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for the patient: ______________________

(Over please)

If the patient is unable to sign, the patient shall mark this release with an "X" and in the presence of two (2) witnesses with their dated signatures below:

NOTE: WE CANNOT CONDITION TREATMENT BASED ON YOUR SIGNING OF THIS AUTHORIZATION

Witness Signature: ______________________________ Date: __________________

Witness Signature: ______________________________ Date: __________________

SECTION C: ATTORNEYS ONLY

If you are an **attorney** making this request pursuant to legal subpoena, discovery request or "other lawful process", in the absence of patient authorization or a court order, you must provide satisfactory assurance that the patient was provided with sufficient notice and opportunity to object to this release of protected information.

(CHECK ALL THAT APPLY)

EITHER

- ☐ You have made a good faith effort (such as by sending a notice to the individual's last known address) to provide written notice to the individual who is the subject of this request, AND
- ☐ The notice identifies the litigation at issue with sufficient specificity to allow the individual to raise an objection, AND
- ☐ The time to raise an objection has passed and no objections were filed, or if filed, were resolved to allow disclosure.

OR

- ☐ In lieu of notice, reasonable efforts were made to secure a "qualified protective order", AND
- ☐ The parties have agreed to the qualified protective order and have presented it to the court or administrative tribunal, OR
- ☐ The party seeking the information has requested a qualified protective order from the court or administrative tribunal.

Attach any written documentation to support the above representatives to this form.

ATTESTATION OF ATTORNEY

I hereby acknowledge that the patient/subject, or patient/subject's legal representative (parent or guardian), was provided with sufficient notice and opportunity to object to this release of protected health information and that an objection or response has not been received. I also represent that the protected health information requested meets the "minimum necessary standard" as described in the HIPAA Privacy Rule.

Attorney Signature: ______________________________________ Date: ____________________
Law Office Address: ____
City/State/Zip Code: ____________________________________ Telephone Number: ______________

Prohibition on Redisclosure (if applicable)
This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by the facility releasing medical records pursuant to the authorization may not be further disclosed.