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

TO BE COMPLETED BY SYSTEM STAFF
Medical Record # _____
CSN#_____

Edward-Elmhurst Health
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Consent Rescinded: Date/Time: Witness:

1. **Patient information**

Patient's Legal Name:	Date of Birth:	Telephone Number:
Street Address:	City, State, Zip Code:	
Approximate dates of treatment* (*Must be completed)		

2. I authorize the use and disclosure of the individually identifiable health information ("PHI") about me that is indicated in the checklist 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)):

- ☐ Emergency Record
- ☐ Immediate Care/Walk-in Clinic
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ Immunizations
- ☐ Report of Operation
- ☐ Pathology Report
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Chemical Dependency Assessments
- ☐ BH Level of Care Assessments
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Cardiac Catheterization Report
- ☐ EKG/EEG/Echo Reports
- ☐ Radiology CDs or Films
- ☐ Physical Therapy, Occupational Therapy or Speech Therapy
- ☐ Physician Office Medical Record
- ☐ Corporate Health/Workers Comp
- ☐ Abstract Copy (Tests, Results, and Typed Reports)
- ☐ Medication List
- ☐ Billing Statement
- ☐ Complete Copy
- ☐ Other: _____

3. **Authorized to Release (FROM):** I authorize the release of my PHI from the entity identified below. (Check appropriate System entity. If facility is not part of the System please write in the facility name and address on the blank lines.)

- ☐ Edward Hospital
- ☐ Elmhurst Memorial Hospital
- ☐ Linden Oaks Hospital
- ☐ Edward Medical Group
- ☐ Linden Oaks Medical Group
- ☐ Elmhurst Medical Group
- ☐ Elmhurst Memorial Primary Care Associates: Addison Elmhurst River Forest Westchester
- ☐ Elmhurst Clinic
- ☐ Elmhurst Medical Associates
- ☐ Facility: _____ Address: _____

4. **Authorized to Receive (TO):** I authorize the Person/Facility/Agency identified below to receive my PHI.

Name and Relationship / Facility and Department: RECORDS DEPOSITION SERVICE, INC	Telephone Number: 248.357.3330
Street Address: PO BOX 5054	Fax Number: 248.357.3337
City, State, Zip Code: SOUTHFIELD, MI 48086 - 5054	

5. **Purpose(s) of the use or disclosure:**

☐ Continuation of Care ☐ Personal ☐ Insurance ☒ Legal ☐ Disability

6. **Purpose(s) of the use or disclosure:**

- ☐ Copy of Record – Mailed to address
- ☐ Copy of Record to be picked up
- ☐ Verbal (LOH Clinical Staff Only)
- ☐ Fax
- ☐ Other: _____
- ☒ Released electronically (select below):
  - ☐ CD
  - ☐ Flash drive
  - ☒ Other: UPLOAD AT WWW.RECDEP.COM OR EMAIL TO INFO@RECDEP.COM

7. 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, 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 re-disclose the information.
   - I may revoke this authorization at any time by giving a written revocation to the System 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 1 year** 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** (Printed Name) *Date*

_____ _____
If not Patient, Describe Relationship of Legally Authorized Representative to Patient (This section must be completed.) Printed Name

_____ _____
Signature of Witness *(Printed Name)* *Date*

_____ _____
*Signature of 2nd Witness (Printed Name) (ONLY if releasing information to the patient, a guardian, or other legal representative pursuant to a verbal consent.)*** *Date*

_____ _____
*Signature of Minor Patient**** (Printed Name) *Date*

******Minor Patients:** 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.*

***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.*

*****Signature of 2nd Witness:** Written consent should be obtained from each patient before releasing information. If unable to obtain written consent due to incapacitation and/or restraint, verbal consent may be obtained if the information will be provided to the patient, a guardian, or other legal representative. The signature of a second witness is required.*