## **Authorization for Release of Patient Health Information**

**INSTRUCTIONS:** This authorization is made by you for the release of your healthcare information, as indicated. Please complete each section. Sections NOT completed may delay the request of information being released. If you decline to consent to the release of information, the records will not be released.

SECTION 1 - Patient Information				
Name:			Date of Birth:	
Address (street, city, state, zip):				
Phone Number(s):			Social Security Number (last 4):	
Home C	ell	Business	xxx-xx	
SECTION 2 - Authorized To Reque				
I request that my medical record info	ormation be sent FROM the person	on(s)/location(s) indicated belo	W.	
	HEALTH SAINT	IOSEPH MEDICA	L CENTER	
Address (street, city, state, zip): 333 NORTH MADISON	STREET, JOLIET, IL 6	60435		
SECTION 3 - Authorized Recipient				
I request that my medical record info If you are requesting <b>access to</b> y			nal information.	
Name:				
Organization: RECORDS DEPOSITIO	N SERVICE, INC.			
Address (street, city, state, zip): P.O. BOX 5054, SOUTH		54		
Phone Number(s):				
Home C	ell	Business 248-357-3330	Fax 248-357-3337	
SECTION 4 - Purpose Of The Use	or Disclosure (e.g. further care	, insurance claim, attorney ir	quiry, personal use, etc.)	
PRE-TRIAL DISCOVERY				
SECTION 5 - Disclosure To Include				
The following information is authorize	red for release for the treatment	dates of:		
This disclosure will include the follow	fing types of reports (check all th	at anniv):		
	sical, Emergency Room Record	· · · · · · · · · · · · · · · · · · ·	port, Pathology Report, Consultation Report,	
☐ Imaging/Radiology Report	☐ Operative Report	☐ History and Physical	☐ Pathology Report	
☐ Emergency Report	☐ Consultation Report	☐ Immunization Record	☐ Itemized Bill	
☐ Progress/Physician Notes	☐ Discharge Summary	☐ EKG/EEG/EMG Report	☐ Entire Chart	
☐ Laboratory Report	☑ Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST			
SECTION 6 - Highly Confidential Inf	ormation To Be Disclosed			
The following highly confidentia	items must be checked off	to be included in the use o	r disclosure of health information:	
☐ HIV/AIDS related health information and/or records (the patient 12 or over must authorize this release)				
<ul> <li>Behavioral or Mental Health Infor patient 12 or over must authorize</li> </ul>		types of records under "Other"	above. Note that release must be witnessed and	
Continued on page 2				

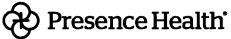
Presence Health



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☐ Information about sexuality transmitted disease (the patient 12 or over must a	st authorize this release)		
☐ Pregnancy (the patient 12 or over must authorize this release)			
☐ Birth Control (the patient 12 or over must authorize this release)			
☐ Drug/Alcohol Diagnosis, Treatment and/or Referral Information (the patient 13	12 or over must authorize this release)		
☐ Genetic Testing Information and/or Records			
☐ Information about Sexual Assault/Abuse			
☐ Information about Child Abuse and Neglect			
SECTION 7 - Authorization Expiration Date			
This authorization is approved for: ☐ This occurrence only ☐ 60 days fi	s from the date of signature Date:		
☐ 1 year from the date of signature (mental health and Presence Life Connection	tion records only)		
Date:*Only effective for this occurrence if none is chose			
SECTION 8 - Please read the following statements carefully:			
related treatment on the provision of an authorization.  I understand that I may change my mind and revoke this authorization at any time by giving writted this authorization will not affect action you took in reliance in this authorization before you received I authorize the use and/or disclosure of my Protected Health Information (PHI) as described about decision so Presence Health may use and/or disclose my PHI for a specific purpose. I understant PHI described above are subject to federal health information privacy laws, they may further discoprivacy laws. However, any mental health, substance abuse, genetic testing or HIV/AIDS informations disclosed except pursuant to my authorization.  I have had full opportunity to read and consider the contents of this authorization and I confirm signing this form, I am confirming my authorization that you may use and/or disclose to the person I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand understand there may be a reasonable charge to obtain a copy of these records. I understand understand there may be a reasonable charge to obtain a copy of these records. I understand understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records. I understand there may be a reasonable charge to obtain a copy of these records.	bevelopmental Disabilities Confidentiality Act, you may not re-disclosure. This information has been disclosure. This information has been disclosure to gathorize the year and that I am entitled to a copy of this capture.		
SECTION 9 - Signature	vestigate or prosecute any accoror or drug abuse patient.		
Patient Signature:	Date:		
Personal Representative Name: (Print)	Personal Representative Phone #:		
Personal Representative Relationship to Patient and Authority:	•		
Personal Representative Signature:	Date:		
Witness Name (required for the release of mental health information):	Date:		
Witness Signature:	Date:		
SECTION 10 - Verification Of Authority  How is the person's identity, authority and relationship to the patient authorized?	Personal representative status (identify as parent,		
	guardian, executor, administrator, power-of-attorney)		
Personal identification	☐ Warrant, subpoena, order, summons, civil investigation or other legal process		
Government credentials			
☐ Authority is known	Witnessed By:		
SECTION 11: Requested Format	SECTION 12: Method of Delivery		
☐ Paper ☑ CD	☑ Mail ☐ Pick-up		





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