Rehabilitation Institute *of* Chicago

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Print Patient Name:______________________ Date of Birth:____/____/____

Address:______________________ City/State/Zip:______________________

Last 4 Digits of SSN:__________ Telephone Number:__________ Medical Record #:__________

I hereby authorize that the protected health information regarding the above-named person be released from:

❑ Rehabilitation Institute of Chicago
345 E. Superior Street, Chicago, IL 60611
Medical Record Department Rm. 1668
Correspondence: (312) 238-1668 phone
(312) 238-2900 fax

❑ Facility:______________________
Address:______________________
City/State/Zip:______________________

❑ Pick-up
❑ Mail

Name of Person/Facility to be released to: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054 City/State/Zip: SOUTHFIELD,MI, 48086-5054

Phone Number: 248-357-3330

Dates of your treatment/service that you want to be released:______________________

Purpose for which you want this information released: PRE TRIAL DISCOVERY

INFORMATION TO BE RELEASED (Check all that apply)

❑ ABSTRACT (History & Physical, Discharge Summary, Consultation Reports, Test Results, Therapy Notes)
❑ Progress Notes ❑ Operative/Procedure/Pathology Reports ❑ Lab Results
❑ Other (Specify): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

The following information will not be released unless I initial below:

________ Psychiatric/mental health and/or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)

________ Records of HTLV-III and/or HIV (AIDS/related illness) testing results, diagnosis, or treatment

________ Genetic Testing

________ Alcohol/drug abuse diagnosis or treatment

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Director of Medical Records except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked, but will expire 1 year after date signed. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information, except in instances defined in THE NOTICE OF PRIVACY PRACTICES. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that there may be copying and/or processing fees associated with this release, such pricing to be disclosed to me upon my request.

______________________ ______________________
Signature of Patient Date

______________________ ______________________
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient

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Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.

(1) Original – Medical Record (2) Copy – Patient