ROCKFORD HEALTH system
Respectful Care

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME ____________________ MAIDEN NAME __________ BIRTHDATE __________ MR# __________
Last Name, First Name, Middle Initial

ADDRESS ____________________ CITY ______________ STATE ____ ZIP ______ PHONE # __________

I authorize:
- ☐ Rockford Health Physicians, 2300 N. Rockton Ave., Rockford, IL 61103
- ☐ Rockford Memorial Hospital, 2400 N. Rockton Ave., Rockford, IL 61103
- ☐ Visiting Nurses Association, 4223 E. State St., Rockford, IL 61108
- ☐ The Women's Center, 7180 Spring Brook Rd., Suite B, Rockford, IL 61114

(x) To Release to: RECORDS DEPOSITION SERVICE, INC.
( ) To Receive from:
(Name of Health Care Facility, Individual, or Agency, etc.)
120 W. MADISON ST., SUITE 300 P: 312-553-8900
(Address)
CHICAGO, IL 60602 F: 312-553-8901
(City/State/Zip)

SPECIFIC INFORMATION TO BE RELEASED:

HOSPITAL RECORDS	ROCKFORD HEALTH PHYSICIAN OFFICE RECORDS	VNA RECORDS
____ Inpatient Date(s): ________	Office notes of : Date(s)	
____ Outpatient Date(s): ________	( )Dr./Dept.________ ________	
____ Emergency Room Date(s): ________	( )Dr./Dept.________ ________	________
____ Radiology Films Date(s): ________	( )Dr./Dept.________ ________	Date(s)
____ Lab (Slides/Blocks) Date(s): ________		
____ Abstract Only *(Discharge Summary, History & Physical, Operative Reports, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)*	( )Lab ________ ( )X-ray Reports ________ ( )EKG ________ ( )Immunization Record ________	
X Other SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED	(X)Other SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED	

- **The purpose of this disclosure of information is** FOR DISCOVERY BEFORE TRIAL
(i.e. continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record **may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, developmental disabilities, treatment for alcohol and/or drug abuse, or genetic testing.**
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I may contact the Director of Health Information Services for questions regarding disclosure of my health information.
- I understand that my refusal to consent to the release of the above mentioned information will prevent the disclosure of the information. I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency. If I refuse to authorize release of information for this purpose, it may adversely affect my entitlement to insurance benefits.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date or event: ______________. If I do not specify an expiration date or event, this authorization will expire in six months.

______________________________ DATE: __________ TIME: ________
Signature of Patient or Legal Representative

____
If signed by other than the patient, state relationship

______________________________ DATE: __________ TIME ________
Witness

-Illinois Mental Health & Developmental Disabilities Confidentiality Act - Chapter 91.5, Section 803 - Minors ages 12 - 17 years old: Patient, parent (legal guardian), and witness must sign and date.
-Minors 12 - 17 years old may authorize the release of alcohol and/or drug abuse information. (Federal Regulation 42CFR)

Original: Medical Record

Rev. 12/04, 10/10, 1/11, 5/12 MR26.91