(For Official Use Only)

PATIENT NAME _____

DATE OF BIRTH _____

MEDICAL RECORD # _____

RUSH

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Authorization for Release of Patient Health Information

IDN13151000

INSTRUCTIONS: This authorization is made by you for the release of your healthcare information, as indicated. Please address questions about this form to: Rush University Medical Center, ATTN: Health Information Management Office, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264.

Form must be completed in its entirety.

PATIENT INFORMATION:

Patient Name _____ (Last Name, First Name, Middle Initial) Maiden Name _____ Birthdate ____/____/____ Phone #_____

Address _____ City_____ State____ Zip_____

MEDICAL INFORMATION REQUESTED FROM: (Check box or fill in information)

☑ Rush University Medical Center ☐ Rush Oak Park Hospital

Individual or Organization's Name: _____ Phone #_____

Address _____ City_____ State____ Zip_____ FAX #_____

RELEASE REQUESTED MEDICAL INFORMATION TO: (Requestor may be billed unless it is a medical office for continuation of care)

☑ Check box if same as patient information above

Individual or Organization's Name: RECORDS DEPOSITION SERVICE, INC. Phone #(248) 357-3330

Address P.O. BOX 5054 City SOUTHFIELD State MI Zip 48086-5054 FAX #(248) 357-3337

EMAIL: REQUESTS@RECDEP.COM

PURPOSE:

☐ Continuation of Care ☐ For Personal Records ☐ Insurance ☐ Legal ☑ Other (specify): FOR DISCOVERY BEFORE TRIAL

DATES: From____/____/____ **To** ____/____/____

DEPARTMENT/FACILITY TO RELEASE RECORDS:

TYPE OF VISIT

☐ Inpatient
☐ Emergency Room
☐ Other _____
_____
_____

☐ Outpatient/Clinic: Dr./Dept. _____ Location _____
Dr./Dept. _____ Location _____
Dr./Dept. _____ Location _____

REQUESTED MEDICAL INFORMATION:

STEP 1 OF 3

☐ Abstract Only
(Most Recent: Discharge Summary, History & Physical, Office Notes, Operative Reports, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)

☐ Entire Medical Record

☑ Other; Or in addition to Abstract, select in Step 2

STEP 2 OF 3 (IF NEEDED)

☐ Billing Statement/Claim
☐ Cardiac Testing Results/ EKG
☐ Consultations
☐ Discharge Summary
☐ Emergency Record
☐ EMG/EEG Reports
☐ History and Physical
☐ Immunization Records
☐ Lab Reports
☐ Mammography
  ☐ Films
  ☐ Reports
☐ Operative Reports
☐ Pathology Reports
☐ Physician Office Record
☐ Progress Notes
☐ Radiology
  ☐ Images
  ☐ Reports
☑ Other, please specify: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

STEP 3 OF 3 (IF NEEDED)

ADDITIONAL INFORMATION TO BE RELEASED*

PATIENT INITIAL AND DATE REQUIRED FOR EACH ITEM

☐ Genetic Testing Initial_____ Date_____
☐ Drug/Alcohol Initial_____ Date_____
☐ HIV Initial_____ Date_____
☐ Mental Health/ Developmental Disability Initial_____ Date_____

*Witness signature required on page 2

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PATIENT NAME _____

DATE OF BIRTH _____

MEDICAL RECORD # _____

RUSH

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-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 written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action Rush took in reliance in this authorization before Rush received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that, if the persons or organizations I authorized above to receive and/or use the PHI described above are subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. I understand that I have a right to inspect and copy the information to be disclosed pursuant to this authorization and that I may obtain a copy of the information by contacting the office listed above.

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 Rush. I understand that, by signing this form, I am confirming my authorization that Rush may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

EFFECTIVE: This authorization request does not apply to any treatment dates beyond the date of signature. You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire, unless mental health records are requested. Otherwise, this authorization will expire ninety (90) calendar days after the date of signature.

PATIENT/PERSONAL REPRESENTATIVE'S SIGNATURE:

_____ Date: _____
Signature of Patient or Personal Representative

_____ Phone # _____
If signed by other than patient: PRINT representative name

_____
If signed by other than patient: State relationship to patient

*(Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if over the age of 12 and under the age of 18.)

_____ Date: _____
Witness signature

_____ Phone # _____
PRINT Witness name

_____
State relationship to patient