SAINT ANTHONY HOSPITAL
AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Print Name: _____ **Date of Birth:** _____

1. **Dates of visit(s) or service(s):**

   _____

2. **Description of Information to be used or disclosed:**

   ☐ History & Physical
   ☐ Operative Report/Pathology Report
   ☐ Emergency Room Report
   ☐ X-Ray Films and/or Radiology Reports
   ☐ Outpatient Record
   ☐ Clinical Resume/Discharge Summary
   ☐ Consultation(s)
   ☐ Laboratory Report(s)
   ☐ Entire Record
   ☒ Other Please see enclosed Subpoena or Letter Request for information to be disclosed.

In order to protect our patients, specific authorization is required to release certain information. If any of the following apply, and you wish to have that information released, you must initial the appropriate box(es):

☐ Treatment of emotional illness, including documentation by any psychologist or psychiatrist (this **does not** include psychotherapy notes)
☐ Treatment of alcohol or substance abuse
☐ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex.

3. **Who is authorized to use or disclose the information (i.e. Saint Anthony Hospital):**

   SAINT ANTHONY HOSPITAL

4. **Who is authorized to receive the information (e.g. name of hospital, law firm, individual):**

   RECORDS DEPOSITION SERVICE, INC., 120 W. MADISON STREET, STE. 300, CHICAGO, IL 60602 P: 312-553-8900 F: 312-553-8901

5. **Reason the information will be used or disclosed (more than one box may be used, but the blanks must be completed if "other" is checked):**

   ☐ At the patient's request
   ☐ For a patient training video or other recording
   ☒ For legal purposes (discovery request, subpoena or other lawful purpose)
   ☐ Other_____
   (If for Saint Anthony Hospital "marketing" purposes indicate whether Saint Anthony Hospital _____ will or will not_____ receive payment as a result of using or disclosing the information. This does not include payment for services provided to the patient.)

6. **Expiration Date or Event:** _____.

   (If no expiration date is specified, this authorization will expire six months after it is signed)

This authorization may be revoked at any time by notifying the Privacy Officer in writing at 2875 West 19th Street, Chicago, IL 60623, but this will not affect disclosures made prior to receipt of the revocation.

Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to re-disclosure by the recipient and may no longer be protected by these laws.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization. I understand that I may refuse to sign this authorization.

SIGNED_____ **DATE**_____
(Patient or Authorized Representative)

Description of Authorized Representative's Authority to Sign:_____

EXHIBIT A