RUSH UNIVERSITY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name:

Date of Birth: _

Medical Record

Place Patient Label

HIM ROl Authorization
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,** 1653 West Congress **Parkway, Suite 101, Chicago, IL** 60612-3833, **Telephone:** (312) 942-7262, Fax: (312) 942-2264.

SECTION 1; Patient Information

Name [Last, First, Ml]				Date of Birth
Address [Street, City, State, Zip]				
Phone Number(s): Home	Cell	Business	Medical Record Number [if known]	Social Security Number {Last 4) XXX-XX-

SECTION 2: Authorized to Request Use or Disclosure (FROM)

I request that my medical record Information be sent **FROM** the person{s)/location(s) indicated below

Name [Last, First, Ml]

Organization

Address [Street, City, State, Zip]

Phone Number(s): Home	Cell	Business	Fax

SECTION 3: Authorized Recipient to Receive (TO)

i request that my medical record information be sent TO the person(s)/!ocation(s) indicated below,
if you are requesting access to your own medical record, please fill In your own personal Information.

Name [Last, First,

Organization

Address [Street, City, State, Zip]

Phone Number(s):

Home Cell Business Fax

SECTION 4: Purpose of the Use or Disclosure

The use or disclosure of my health information is requested for the following purposes (such as continuing care, attorney, self, employer, other):

SECTION S: Information to be Disclosed

The foliowina tvoe of information is authorized for release [initial next to each tvoel for the oeriod of to

1 i General Medical	1 ! Substance Abuse
□ HiV Records	□ Mental Health and Developmental Disability Treatment Records
□ Genetic Testing Records	□ Other

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SECTION 6: Disclosure to Include

This disclosure wiii include the following types of reports:

□ X-Ray/Radiology Report	□ Operative Report	L.j History and Physical	□ Pathologq Report
□ Emergency Report	□ Consulting Report	□ Immunization Record	□ Itemized Bill
□ Progress/Physician Notes	□ Discharge Summary	□ EKG/EEG/EMG Report	
□ Films/Siides	□ Other:		
□ Laboratory Report			

SECTION 7: Authorization Expiration Date

This authorization is approved for:

□ This occurrence only

□ 60 days from the date of signature

□ On occurrence of the following event (which must relate to the individual or to the purpose of the use/or disclosure being authorized)

SECTION 8: 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 you took in reliance in this authorization before you received my writien 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, t 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. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by Rush pursuant to the authorization may not be further disclosed except pursuant to my authorization.

1 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 you. i understand that, by signing this form, i am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the PHi described in this form.

SECTION 9: Signature

Patient Signature	Date
Personal Representative Name [Last, First, Ml]	Personal Representative Phone Number
Personal Representative Relationship to Patient and Authority:	
Personal Representative Signature	Date
Witness Name [Last, First, Ml] (Required for the release of mental health information]	Date
Witness Signature	Date

I SECTION 10: Verification of Authority

How is the oerson's identity, authority, and relationship to the patient authorized?

Pi Personal Identification	□ Persona! representative status {identify as parent, auardian. executor, administrator, power of attorney)
r I Government credentials	
f l Authority is known	□ Warrant, subpoena, order, summons, civil investiaation. or other legal process

Copy provided to the individual