



# Resurrection Medical Center

7435 W. Talcott Avenue, Chicago, IL 60631  
Phone: (773) 990-5703 Fax: (773) 792-7911

## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

**INSTRUCTIONS:** This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

### SECTION 1 - Patient Information

|  |             |   |   |
|--|-------------|---|---|
| Patient Full Name - First, Middle, Last: |             | Birthdate:<br>Month _____ Day _____ Year _____        |   |
| Patient Address - Street/Apt/Suite:      | City:       | State:  | Zip:  |
| Phone Number:                            | Fax Number: | Social Security Number (Last 4)<br><b>XXX-XX-____</b> | OFFICE USE ONLY: Patient MRN/Encounter Number |

### SECTION 2 - Disclosure of Health Information

I authorize \_\_\_\_\_ to ☐ Disclose ☐ Obtain ☐ Disclose and Obtain

#### Disclose To

(facility name)

Name of Facility/Entity/Individual:

|                           |             |        |      |
|---------------------------|-------------|--------|------|
| Street Address/Apt/Suite: | City:       | State: | Zip: |
| Phone Number:             | Fax Number: |        |      |

#### Obtain From

Name of Facility/Entity/Individual:

|                           |   |        |      |
|---------------------------|---|--------|------|
| Street Address/Apt/Suite: | City:   | State: | Zip: |
| Phone Number:             | <b>For Direct Patient Care Only</b> - Fax Number: |        |      |

### SECTION 3 - Purpose Of Disclosure

- |                                    |                                       |   |   |
|------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Legal     | <input type="checkbox"/> School       | <input type="checkbox"/> Further Care/Treatment | <input type="checkbox"/> Transfer/Placement |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other (specify) _____  |   |

### SECTION 4 - Requested Format

- ☐ Paper ☐ Electronic Media ☐ Verbal Disclosure (For Use in Behavioral Health Programs Only)

### SECTION 5 - Delivery Method

- ☐ Mail ☐ Pick-Up ☐ Secure Email (email address) \_\_\_\_\_ ☐ Verbal Disclosure (For Use in Behavioral Health Programs Only)

### SECTION 6 - Dates of Treatment

Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017): \_\_\_\_\_

### SECTION 7 - Medical/Surgical Health Information To Be Disclosed - Check All That Apply

- |  |  |
|--|--|
| <input type="checkbox"/> Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests). |  |
| <input type="checkbox"/> Emergency Report  | <input type="checkbox"/> Clinic Notes (specify clinic) _____         |
| <input type="checkbox"/> History and Physical(s)   | <input type="checkbox"/> Rehab or Therapy Notes (specify type) _____ |
| <input type="checkbox"/> Consultation(s)   | <input type="checkbox"/> Prenatal Summary _____                      |
| <input type="checkbox"/> Progress Note(s)  | <input type="checkbox"/> Entire Chart                                |
| <input type="checkbox"/> Operative/Procedure Report(s)   | <input type="checkbox"/> Itemized Bill                               |
| <input type="checkbox"/> Laboratory Results  | <input type="checkbox"/> Other (specify) _____                       |
| <input type="checkbox"/> Pathology Results   | <input type="checkbox"/> Discharge Summary                           |
| <input type="checkbox"/> Radiology Report(s)   |  |
| <input type="checkbox"/> Radiology films/digital images  |  |
| <input type="checkbox"/> EKG/Stress Test(s)  |  |



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**SECTION 8 – Specific Consent MUST BE COMPLETED FOR ALL REQUESTS**

If any of the highly confidential information listed below is contained in the medical records requested, I am specifically authorizing the use and/or disclosure of this information by checking the boxes below, if applicable to this authorization.

- |   |  |
|---|--|
| <input type="checkbox"/> Information about Mental/Behavioral Care and Treatment         | <input type="checkbox"/> Information about Sexually Transmitted Disease(s) |
| <input type="checkbox"/> Information about Substance Abuse Care and Treatment           | <input type="checkbox"/> Information about Genetic Testing                 |
| <input type="checkbox"/> Information about Psychological Testing                        | <input type="checkbox"/> Information about Sexual Assault/Abuse            |
| <input type="checkbox"/> Information about HIV/AIDS Testing or Treatment                | <input type="checkbox"/> Information about Child Abuse and Neglect         |
| <input type="checkbox"/> Pregnancy (the patient 12 or over must authorize this release) | <input type="checkbox"/> Not Applicable to this authorization              |

**SECTION 9 – Behavior Health/Substance Use Disorder Treatment Information To Be Disclosed****Behavioral/Substance Abuse Health Information To Be Disclosed – Check All That Apply**

- ☐ Inpatient Stay: An abstract of the record will be provided, which includes Test Results, History and Physical, Psychiatric Evaluation, Consultations, Discharge Summary, Face Sheet, unless otherwise specified.

- |  |   |
|--|---|
| <input type="checkbox"/> History & Physical Screen | <input type="checkbox"/> Dates of Admission and Discharge |
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Progress Notes                   |
| <input type="checkbox"/> Psychiatric Evaluation    | <input type="checkbox"/> Medication information           |
| <input type="checkbox"/> Psychological Testing     | <input type="checkbox"/> Laboratory Results               |
| <input type="checkbox"/> Psychological Evaluation  | <input type="checkbox"/> Radiology Results                |
| <input type="checkbox"/> Treatment Plan            | <input type="checkbox"/> Assessment (specify type) _____  |
| <input type="checkbox"/> Itemized Bill/Insurance   | <input type="checkbox"/> Behavioral/History of Client     |
| <input type="checkbox"/> Other (specify) _____     |   |

**Education Department**

- |  |   |
|--|---|
| <input type="checkbox"/> Psychiatric Diagnosis | <input type="checkbox"/> Attendance/Tuition |
| <input type="checkbox"/> Medical Diagnosis     | <input type="checkbox"/> CD Diagnosis       |
| <input type="checkbox"/> Treatment Information | <input type="checkbox"/> Follow Up Care     |
| <input type="checkbox"/> Homework Information  | <input type="checkbox"/> IEP of 504 Plan    |

**SECTION 10 – Authorization Expiration Date**

- This authorization is approved for: ☐ This occurrence only ☐ 60 days from the date of signature  
☐ 1 year from the date of signature (mental health records only) \*Only effective for this occurrence if none is chosen.

**SECTION 11 – Important Information****I have read and understand the following statements:**

**Note: If the authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the date the request is received. If this authorization is for medical/surgical or research, an expiration date is not required.**

**I understand** that my health information may be shared with other Ascension Illinois healthcare providers for the purposes of treatment and care coordination.

**I understand** that I have the right of access to inspect and obtain a copy of my health information.

**I understand** that I can cancel this authorization at any time by submitting a written notice to the physician office or **Health Information Management Department of the hospital where my health information is stored**. I understand that my cancellation will take effect when the Health Information Management Department receives my written notice.

**I understand** that my cancellation will not have any effect on health information released before the Health Information Department received my written notice.

**I understand** that health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

**I understand** that under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

**I understand** that failure to provide all required information on this authorization form will not constitute a proper authorization to disclose protected health information, including the refusal to sign this authorization and that, therefore, my request may not be honored.

**I understand** that refusal to sign this authorization will not affect any conditions of my treatment, payment, enrollment, or eligibility for benefits.

**SECTION 12 – Signatures**

**\*Patients 12-17 years of age** must sign for Behavioral Health, Substance Abuse, HIV/AIDS, STD, Pregnancy, Birth Control information.

**\*\*Legal Representative or Guardian**, please attach a court order or other documentation designating your legal status, as applicable.

**\*\*\*Signature of witness** who can attest to the identity of the authorized signatory is required to release any mental health or developmental disability information. The witness cannot be the same person as the authorized signatory.

|  |                           |   |                           |
|--|---------------------------|---|---------------------------|
| _____/_____/_____<br>*Signature of Patient | _____/_____/_____<br>Date | _____/_____/_____<br>*** Signature of Witness | _____/_____/_____<br>Date |
|--|---------------------------|---|---------------------------|

|  |                           |   |
|--|---------------------------|---|
| _____/_____/_____<br>**Signature of Parent, Legal Representative or Legal Guardian | _____/_____/_____<br>Date | _____<br>Relationship of Parent, Legal Representative or Legal Guardian |
|--|---------------------------|---|



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