West Suburban Medical Center

Patient Label

AUTHORIZATON FOR RELEASE OF MEDICAL RECORD INFORMATION

Date: _____

Name of Patient: _____ Medical Record Number: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Telephone Number: _____

PLEASE RELEASE THE MEDICAL RECORDS FROM:

☐ **West Suburban Medical Center**

☐ Other: _____

INFORMATION REQUESTED: (Check all that apply)

☐ Medical/Legal Abstract ☐ Lab Results ☐ Radiology Imaging Report/Films

☐ Discharge Summary ☐ Outpatient Report ☐ Emergency Room Report

☐ History and Physical ☐ Other (Please specify): _____

MY HIGHLY CONFIDENTIAL INFORMATION: *By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.*

☐ Psychiatric/mental health, mental retardation or developmental disabilities information (Parent/guardian co-signature required for the release of psychiatric information of patients 12-17 years old)

☐ HIV and AIDS testing, diagnosis or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

☐ Communicable disease, including sexually-transmitted diseases diagnoses/lab results/treatment

☐ Alcohol/drug abuse or addiction diagnosis/treatment

☐ Child abuse and neglect ☐ Domestic abuse by an adult ☐ Sexual assault ☐ Genetic testing

Dates of Treatment:_____

PURPOSE: I authorize West Suburban Medical Center to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ Continuing Medical Care ☐ Personal Use ☐ Attorney/Legal Case

☐ Disability/Insurance Application or Claim ☐ Other (specify): _____

Term that this Authorization will remain in effect:

☐ From the date of this Authorization until _____ ☐ Until the following event occurs:_____

☐ Until West Suburban fulfills this request ☐ Other (specify): _____

METHOD OF DELIVERING INFORMATION:

☐ I will pick up the records at the above Health Information Management (Medical Record) Department.

☐ Please send an electronic copy of my medical record to:

Release to:_____ Email: _____

☐ Please mail the records to:

Release to: _____

Address: _____City: _____State: _____ZipCode: _____

Phone: _____Fax:_____

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AUTHORIZATON FOR RELEASE OF MEDICAL RECORD INFORMATION

I understand that once West Suburban Medical Center discloses my health information to the recipient, West Suburban Medical Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that West Suburban Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at West Suburban Medical Center except, however, if my treatment at West Suburban Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case West Suburban Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to West Suburban Medical Center's Privacy Officer at the address listed below. The revocation will be effective immediately upon West Suburban Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by West Suburban Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact West Suburban Medical Center Privacy Office by mail at West Suburban Medical Center, 3 Erie Court, Oak Park, IL 60302 or by telephone at 708-763-2619.

CHARGES FOR INFORMATION:

I understand that I may be charged for the copies as follows: Medical records will be copied at an allowable charge. All information mailed will be subject to actual postage or other delivery fees.

I understand that I may be charged for the copies of records I have requested and for postage. I agree to pay the total charges when I pick up the copies or, if the copies are to be mailed to me, I agree to pay the invoice charges.

IF YOU ARE NOT THE PATIENT:

Please print your name: _____

Please state your relationship to patient: _____

What gives you authority to receive the patient's information?

☐ Written patient authorization (please attach)
☐ You are the patient's parent or guardian (please attach evidence)
☐ You are the patient's Health Care Power of Attorney (please attach evidence, such as a medical power of attorney)
☐ The patient is deceased and you are the personal representative of the patient's estate (please attach evidence)
☐ Other: _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize West Suburban Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**