RUSH UNIVERSITY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: ___________________________________

Date of Birth: ___________________________________

Medical Record #: ________________________________

Place Patient Label

Purpose: This form is used to confirm the direction of an individual that Rush may use or disclose protected health information for a particular purpose.

ROI-P
Authorization for Release of
Patient Health Information

IDN13150025

Purpose of the Requested Use or Disclosure: (must check one)

☐ Fundraising ☐ Marketing ☐ Media Purposes ☐ Patient's Employer ☐ Patient's Attorney ☐ Self

☐ Other (please describe) ____

Rush does not require an authorization for the release of protected health information for treatment, payment, or health care operations except in the case of mental health, HIV, or substance abuse records.*

Please provide us with the following information:

Patient's Name:	Telephone Number:
Address:	
City/State/Zip Code:	Med. Record # (if known)
Social Security Number:	Date of Birth:

SECTION A: What is being authorized for release.
Please check and initial the specific protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization).

☐ General Medical Initial: ______________ ☐ Genetic Testing Initial: ______________
☐ Mental Health* Initial: ______________ ☐ HIV/AIDS* Initial: ______________
☐ Alcohol/Substance Abuse* Initial: ______________ ☐ Physician Name / Dept. of Service Initial: ______________

☐ Other (please specify): ____

SECTION B: Entities Authorized to Use or Disclose: Identify the persons and/or organizations who you are authorizing to make the requested use or disclosure.
☐ Rush University Medical Center ☐ Lab Only ☐ Radiology Only

☐ Specific Department or Other: (please list) ________________________________

SECTION C: Entities Authorized to Receive and Use: Identify the persons and/or organizations who you are authorizing to receive the protected health information described in Section A.
☐ Rush University Medical Center ☐ Patient's Attorney ☐ Patient's Employer

☐ Other: ____

☐ Address of person and/or organization: ________________________________

SECTION D: Authorization Expiration date: (must check one).
☐ This occurrence only ☐ 60 days from 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 E: 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.

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SECTION F: Patient (or Patient's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section A above, I understand this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my medical information for a specific purpose. I understand that, if the persons or organizations I authorized above to receive and/or use the protected health information (PHI) described above are subject to federal health information privacy laws, they may further disclose the protected health information 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.

SECTION G: Compensation (must check one if authorization is for Marketing).

☐ Rush **will not** receive direct or indirect compensation from a third party as a result of the use and/or disclosure of the protected health information requested by this authorization.

☐ Rush **will** receive direct or indirect compensation, grants or contracts from a third party as a result of the use and/or disclosure of the protected health information requested by this authorization.

Right to Revoke: 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 below. I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Information: Health Information Management, Rush University Medical Center, 1653 West Congress Parkway, Suite 101 Chicago, IL 60612 • Telephone: (312) 942-7262 • Fax: (312) 942-2264

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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 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 protected health information described in this form.

Signature: ____ **Date:** ______________

If a personal representative on behalf of the patient signs this authorization, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ___________________________________ **Date:** ______________

If this authorization is for mental health records, this authorization must be witnessed below.

Name of Witness: ____ **Date:** ______________

Signature of Witness: ____

TO BE COMPLETED BY RUSH WORKFORCE MEMBER

SECTION H: Verification of Identity & Authority: How did you verify the person's identity and relationship to the individual or to the company, organization or government agency? **Always try to obtain a copy of what you relied upon to identify the person. Attach the copy to this form.**

☐ Personal identification (e.g., driver's license, photo ID) ☐ I know the person

☐ Government credentials (e.g., badge, identification card, and appropriate document on government letterhead).

Identify the authority of the person to receive access to the protected health information to be disclosed.
(You do not need to verify authority to disclose to a properly identified individual or patient who is the subject of the information.)

☐ Authority of the person is known: explain ____

☐ Personal representative status (e.g., identification as parent, guardian, executor, administrator, power of attorney).

☐ Warrant, subpoena, order, summons, civil investigation demand or other legal process.