

RUSH UNIVERSITY MEDICAL CENTER  
**AUTHORIZATION FOR RELEASE OF  
 PATIENT HEALTH INFORMATION**

HIM ROI Authorization  
 Authorization for Release of  
 Patient Health Information



IDN13151000

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

**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, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264.**

**SECTION 1: Patient Information**

Name [Last, First, MI]			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, MI]			
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)/location(s) indicated below.  
 If you are requesting **access to your own medical record**, please fill in your own personal information.

Name [Last, First, MI]			
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 5: Information to be Disclosed**

The following type of information is authorized for release [**initial next to each type**] for the period of \_\_\_\_\_ to \_\_\_\_\_.

<input type="checkbox"/> General Medical _____	<input type="checkbox"/> Substance Abuse _____
<input type="checkbox"/> HIV Records _____	<input type="checkbox"/> Mental Health and Developmental Disability Treatment Records _____
<input type="checkbox"/> Genetic Testing Records _____	<input type="checkbox"/> Other _____

**RUSH UNIVERSITY MEDICAL CENTER  
AUTHORIZATION FOR RELEASE OF  
PATIENT HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

**SECTION 6: Disclosure to Include**

This disclosure will include the following types of reports:

<input type="checkbox"/> X-Ray/Radiology Report	<input type="checkbox"/> Operative Report	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Emergency Report	<input type="checkbox"/> Consulting Report	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Progress/Physician Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG/EEG/EMG Report	
<input type="checkbox"/> Films/Slides	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Laboratory Report			

**SECTION 7: Authorization Expiration Date**

This authorization is approved for:

<input type="checkbox"/> This occurrence only	<input type="checkbox"/> 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 written 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. I 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.

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 PHI described in this form.

**SECTION 9: Signature**

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

**SECTION 10: Verification of Authority**

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

<input type="checkbox"/> Personal Identification _____	<input type="checkbox"/> Personal representative status (identify as parent, guardian, executor, administrator, power of attorney) _____
<input type="checkbox"/> Government credentials _____	
<input type="checkbox"/> Authority is known _____	<input type="checkbox"/> Warrant, subpoena, order, summons, civil investigation, or other legal process _____