RUSH
Rush Copley Medical Center

HIM ROI Authorization

Affix Patient Sticker Here

AUTHORIZATION TO RELEASE HEALTH INFORMATION
There may be a fee for copies

Patient Name:_____ MR#_____

Date of Birth____/____/____ Telephone (____)_____

I hereby authorize Copley Memorial Hospital to:

RELEASE TO: OBTAIN FROM:

Person/Facility Agency _____ _____
Address _____ _____
City, State, Zip _____ _____

Requested Format: ☐ Paper ☐ CD ☐ Patient Portal (Email address:_____)

Specific description of information that may be used / disclosed:

- ☐ INPATIENT Dates of Treatment _____
- ☐ OUTPATIENT Dates of Treatment _____
- ☐ EMERGENCY ROOM Dates of Treatment _____
- ☐ Please provide complete medical record (includes inpatient, outpatient, and emergency room)
- ☐ Please provide abstract of requested information
- ☐ Other _____

The information will be used/disclosed for the following purpose:

☐ Continuing Care ☐ Personal ☐ Legal ☐ Other _____

I authorize Copley Memorial Hospital to release sensitive information as indicated:

- ☐ AIDS/HIV ☐ Drug/Alcohol Abuse ☐ Behavioral Health
- ☐ Sexual Assault ☐ Child Abuse ☐ Developmental Disabilities
- ☐ Genetic Testing

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:

(a) Action has been taken in reliance on this authorization; or
(b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy of the policy itself.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

This authorization will expire on the following date, event, or conditions_____

_____

Signature

_____ _____
Patient Date

_____ _____
Personal Representative Relationship to Patient

_____ _____
Witness Relationship to Patient

We are required by law to respond to this request within 30 days of receipt of the request.