RUSH

HIM ROI Authorization

Affix Patient Sticker Here

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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 and Rush Oak Park Hospital, ATTN: Health Information Management Office, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264 or to Rush Copley Medical Center, ATTN: Health Information Management Office, 2000 Ogden Avenue, Aurora, IL 60504, Telephone: (630) 978-6786, Fax (630) 978-6858.

PATIENT INFORMATION:

Patient Name: _____ Maiden Name:_____ Birthdate ___/___/___ Phone #:_____
Last Name, First Name, Middle Initial

Address:_____ City:_____ State:____ Zip:_____

MEDICAL INFORMATION REQUESTED FROM: (Check box or fill in information)

☐ Rush University Medical Center ☐ Rush Oak Park Hospital ☐ Copley Memorial Hospital ☐ Rush Aurora Surgery Center ☐ Rush Medical Group

☐ Individual or Organization's Name:_____ Phone #:_____

Address:_____ City:_____ State:____ Zip:_____ FAX #:_____

RELEASE REQUESTED MEDICAL INFORMATION TO: (Requestor may be billed unless it is a medical office for continuation of care)

☐ Check box if same as patient information above

Individual or Organization's Name:_____ Phone #:_____

Address:_____ City:_____ State:____ Zip:_____ FAX #:_____

PURPOSE:

☐ Continuation of Care ☐ For Personal Records ☐ Insurance ☐ Legal ☐ Other (specify):_____

PREFERRED FORMAT: ☐ Paper* ☐ CD* ☐ Fax to Number:_____ ☐ Secure Email address:_____
*If you choose Paper or CD: ☐ Call Patient for Pick-up ☐ Mail to Patient Address Above

DATES: From / / To / / . (See "Effective" paragraph on Page 2)

LOCATION OF RECORDS BEING REQUESTED:

TYPE OF VISIT:	☐ Outpatient / Clinic:	Dr./Dept: _____
☐ Inpatient		Location: _____
☐ Emergency Room		Dr./Dept: _____
☐ Other _____		Location: _____
_____		Dr./Dept: _____
_____		Location: _____

REQUESTED MEDICAL INFORMATION:

STEP 1 OF 3

☐ Abstract Only (Discharge Summary, History & Physical, Office/Progress Notes, Operative Reports, ED Notes, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)

☐ Entire Medical Record

☐ Other; Or in addition to Abstract, section in Step 2

STEP 2 OF 3 (IF NEEDED)

☐ Cardiac Testing Results/ EKG
☐ Consultations
☐ Discharge Summary
☐ Emergency Record
☐ EMG/EEG Reports
☐ History & Physical
☐ Immunization Records
☐ Lab Reports
☐ Mammography
  ☐ Films
  ☐ Reports
☐ Operative Reports
☐ Pathology Reports
☐ Physician Office Record
☐ Progress Notes
☐ Radiology
  ☐ Images
  ☐ Reports

_____
_____
_____
_____
_____

STEP 3 OF 3 (IF NEEDED)

ADDITIONAL INFORMATION TO BE RELEASED*

PATIENT INITIAL AND DATE REQUIRED FOR EACH ITEM

☐ Genetic Testing Initial:_____ Date:_____
☐ Drug/Alcohol Initial:_____ Date:_____
☐ HIV Initial:_____ Date:_____
☐ Mental Health/ Developmental Disability Initial:_____ Date:_____

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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 Rush took in reliance on this authorization before Rush 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 not 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. I understand that I have a right to inspect and copy the information to be disclosed pursuant to this authorization and that I may obtain a copy of the information by contacting the office listed above.

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 Rush. I understand that, by signing this form, I am confirming my authorization that Rush may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

EFFECTIVE: This authorization request does not apply to any treatment dates beyond the date of signature. You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire, unless mental health records are requested. Otherwise, this authorization will expire ninety (90) calendar days after the date of signature.

_____

_____

PATIENT/PERSONAL REPRESENTATIVE'S SIGNATURE:

_____ Date: _____
Signature of Patient or Personal Representative

_____ Phone #:_____
If signed by other than patient: PRINT Representative Name

_____
If signed by other than patient: State Relationship to Patient

*(Signature of a witness who has verified the patient /personal representative's identity is required for genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if over the age of 12 and under the age of 18.)

_____ Date: _____
Witness Signature

_____ Phone #:_____
PRINT Witness Name

_____
State Relationship to Patient