(For Official Use Only)

| PATIENT NAME |
|------------------|
| DATE OF BIRTH |
| MEDICAL RECORD # |

1 RUSH

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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

| PATIENT INFORMATION | i: | | | | | |
|---|------------------------------|-----------------------------------|----------------------------|------|-----------|--|
| Patient Name: Last Name, F | First Name, Middle Initial | Maiden Name: | Birthdate: | // | Phone #:_ | |
| | | | | | | |
| MEDICAL INFORMATIO | N REQUESTED FROM: | (Check box or fill in information | on) | | | |
| ☐ Rush University Medica | al Center 🗌 Rush Oa | k Park Hospital 🗆 Copley | Memorial Hospital | | | |
| ☐ Rush Aurora Surgery C | Center Rush Medic | al Group | | | | |
| | | | | | | |
| Address: | | City: | State: | Zip: | FAX #:_ | |
| | | City: | | | | |
| Address: | | City: | State: | Zip: | FAX #:_ | |
| ☐ Continuation of Care | | ds □ Insurance □ Lega | | | | |
| PREFERRED FORMAT: | · | ax to Number: | | | | |
| | *If you choose Paper of | CD. Gail Falletil for Fil | | | | |
| | | _/ (See "Effective" pa | agraph on Page 2 |) | | |
| DATES: From/ | _/ To/ | _/ (See "Effective" pa | agraph on Page 2 |) | | |
| DATES: From/ LOCATION OF RECORD | _/ To/ | _/ (See "Effective" pa | | | | |
| DATES: From/ LOCATION OF RECORD TYPE OF VISIT | _/ To/ | _/ (See "Effective" pa | Dr./Dept. | | | |
| DATES: From/ LOCATION OF RECORD TYPE OF VISIT Inpatient | _/ To/ | _/ (See "Effective" pa | Dr./Dept | | | |
| DATES: From/ LOCATION OF RECORD TYPE OF VISIT Inpatient Emergency Room | _/ To/ OS BEING REQUESTED | / (See "Effective" pa | Dr./Dept Location Dr./Dept | | | |
| DATES: From/ LOCATION OF RECORD TYPE OF VISIT Inpatient Emergency Room Other | _/ To/ OS BEING REQUESTED | / (See "Effective" pa | Dr./Dept | | | |
| DATES: From/_ LOCATION OF RECORD TYPE OF VISIT Inpatient Emergency Room Other | _/ To/ OS BEING REQUESTED | / (See "Effective" pa | Dr./Dept Location Dr./Dept | | | |

| REQUESTED MEDICAL INFORMATION: | | | | | |
|---|---|---|-------------------|--|--|
| STEP 1 OF 3 STEP 2 OF 3 (IF NEEDED) | | | STEP 3 OF 3 (IF N | EEDED) | |
| □ 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, select in Step 2 | □ 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 | ТО | DNAL INFOR BE RELEAS D DATE REQUI Initial: Initial: Initial: | |

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W RUSH AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

| PATIENT NAME | |
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| DATE OF DIDTU | |
| DATE OF BIRTH | |
| MEDICAL RECORD # | |
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State Relationship to Patient

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: | |
|---|--|
| Signature of Patient or Personal Representative | Date: |
| If signed by other than patient: PRINT Representative Name | Phone #: |
| If signed by other than patient: State Relationship to Patient | _ |
| *(Signature of a witness who has verified the patient/personal represent drug/alcohol records. Additionally, signature of <u>patient</u> is required for ment of 18.) | tative's identity is required for genetic testing, HIV, and all health records if over the age of 12 and under the age |
| Witness Signature | Date: |
| PRINT Witness Name | Phone #: |

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