RUSH OAK BROOK SURGERY CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Medical Record #:** _____

Address: _____ **City/State/Zip:** _____ **Phone:** _____

Please RELEASE information FROM:	**Please RELEASE information TO:**
_____ Name	_____ Name
_____ Street Address	_____ Street Address (or specified fax number)
_____ City/State/Zip	_____ City/State/Zip
_____ Telephone Number	_____ Telephone Number
_____ Fax Number	_____ Fax Number

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

_____

_____

For the Purpose of: Patient Care Insurance Claim Self Other _____

List specific dates of records to be released: _____

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows: _____ (date or event.)

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see back of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see back of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: _____ Date _____ Time _____
(Patient / legal representative)

If signed by other than patient, indicate relationship:

_____

Retain in Patient Record

FM-800240 (09/14)

RUSH OAK BROOK SURGERY CENTER

For Office Use Only

Date Received: _____ **Date Information Released:**_____

Copy of verification of identity of individual and/or legal representative obtained/filed.

Notes: _____

_____

Medical Records Number: _____

Medical Records Specialist's Initials: _____

REVOCATION AUTHORIZATION

Patient Portion:

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the
Above Authorization
Authorization releasing information to _____
Authorization dated _____

Signature: _____
(Patient / legal representative) Date Time

If signed by other than patient, indicate relationship: _____

For Office Use Only

Date Revocation Received: _____

_____ _____
Medical Record Number **Medical Records Specialist's Initials**

Exceptions:

The exceptions noted in the Rights section on front of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.