(For Official Use Only)

NAME OF DECEASED _____

DATE OF BIRTH _____

MEDICAL RECORD # _____

RUSH

AUTHORIZATION RELATIVE CERTIFICATION

Deceased

Authorized Relative Certification

IDN1510339

INSTRUCTIONS: This authorization is made by you for the release of the deceased's 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.

DECEASED INFORMATION:

Name of Deceased _____ Maiden Name _____ DOB ___/___/___ 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

Individual or Organization's Name: _____ Phone # _____

Address _____ City _____ State ____ Zip _____ FAX # _____

RELEASE REQUESTED MEDICAL INFORMATION TO: (Recipient will be billed)

☐ Check box if same as deceased information above

Individual or Organization's Name: _____ Phone # _____

Address _____ City _____ State ____ Zip _____ FAX # _____

PURPOSE:

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

DEPARTMENT/FACILITY TO RELEASE RECORDS: DATES: ___/___/___ **to** ___/___/___

TYPE OF VISIT

☐ Inpatient
☐ Emergency Room
☐ Other _____
_____
_____

☐ Outpatient/Clinic: Dr./Dept. _____
Location _____
Dr./Dept. _____
Location _____
Dr./Dept. _____
Location _____

REQUESTED MEDICAL INFORMATION:

STEP 1 OF 3

☐ Abstract Only
(Most Recent: Discharge Summary, History & Physical, Office Notes, Operative Reports, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)

☐ Entire Medical Record

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

STEP 2 OF 3 (IF NEEDED)

☐ Billing Statement/Claim
☐ Cardiac Testing Results/ EKG
☐ Consultations
☐ Discharge Summary
☐ Emergency Record
☐ EMG/EEG Reports
☐ History and Physical
☐ Immunization Records
☐ Lab Reports
☐ Mammography
  ☐ Films
  ☐ Reports
☐ Operative Reports
☐ Pathology Reports
☐ Physician Office Record
☐ Progress Notes
☐ Radiology
  ☐ Images
  ☐ Reports
☐ Other, please specify:
_____
_____
_____
_____

STEP 3 OF 3 (IF NEEDED)

ADDITIONAL INFORMATION TO BE RELEASED*

AUTHORIZED RELATIVE'S INITIAL AND DATE REQUIRED FOR EACH ITEM

☐ Genetic Testing Initial_____ Date_____
☐ Drug/Alcohol Initial_____ Date_____
☐ HIV Initial_____ Date_____
☐ Mental Health/ Developmental Disability Initial_____ Date_____

*Witness signature required on page 2

(For Official Use Only)

RUSH

AUTHORIZATION RELATIVE CERTIFICATION

Deceased

NAME OF DECEASED _____

DATE OF BIRTH _____

MEDICAL RECORD # _____

Authorized Relative Certification

IDN1510339

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

I certify that I am an authorized relative of the deceased. (Authorized Relative must provide a certified copy of the death certificate, which must be attached.)

I certify that to the best of my knowledge and belief that no executor or administrator has been appointed for the deceased's estate, that no agent was authorized to act for the deceased under a power of attorney for health care, and the deceased has not specifically objected to disclosure in writing.

I certify that I am the surviving spouse of the deceased or that there is no surviving spouse and my relationship is (must circle one):

(1) An adult son or daughter of the deceased.
(2) A parent of the deceased.
(3) An adult brother or sister of the deceased.

I certify that I am seeking the records as a personal representative who is acting in a representative capacity and who is authorized to seek these records under Section 8-2001.5 of the Illinois Code of Civil Procedure.

THIS CERTIFICATION IS MADE UNDER PENALTY OF PERJURY.*

This authorization is voluntary. 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. 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 the deceased's 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 the deceased's 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.

EFFECTIVE: This authorization request does not apply to any dates beyond date of signature. This authorization will expire in ninety (90) days.

*(Note: Perjury is defined in Section 32-2 of the Illinois Criminal Code of 1961, and is a Class 3 felony.)

AUTHORIZED RELATIVE'S SIGNATURE:

_____ Date: _____
Authorized Relative's Signature

_____ Phone # _____
Authorized Relative's Name

_____ _____
Authorized Relative's Address State Relationship to Deceased

*(Signature of a witness is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records.)

_____ Date: _____
Witness signature

_____ Phone # _____
PRINT Witness name