



HIM ROI Authorization

Affix Patient Sticker Here

AUTHORIZATION TO RELEASE 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 Copley Surgicenter 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:

<p>TYPE OF VISIT:</p> <p><input type="checkbox"/> Inpatient</p> <p><input type="checkbox"/> Emergency Room</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Outpatient / Clinic: Dr./Dept: _____</p> <p>Location: _____</p> <p>Dr./Dept: _____</p> <p>Location: _____</p> <p>Dr./Dept: _____</p> <p>Location: _____</p>
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REQUESTED MEDICAL INFORMATION:

STEP 1 OF 3	STEP 2 OF 3 (IF NEEDED)	STEP 3 OF 3 (IF NEEDED)
<input type="checkbox"/> Abstract Only (Discharge Summary, History & Physical, Office/Progress Notes, Operative Reports, ED Notes, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports) <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Other; Or in addition to Abstract, section in Step 2	<input type="checkbox"/> Cardiac Testing Results/ EKG <input type="checkbox"/> Consultations <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> EMG/EEG Reports <input type="checkbox"/> History & Physical <input type="checkbox"/> Immunization Records <input type="checkbox"/> Lab Reports <input type="checkbox"/> Mammography <input type="checkbox"/> Films <input type="checkbox"/> Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Physician Office Record <input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiology <input type="checkbox"/> Images <input type="checkbox"/> Reports _____ _____ _____	<p>ADDITIONAL INFORMATION TO BE RELEASED*</p> <p><small>PATIENT INITIAL AND DATE REQUIRED FOR EACH ITEM</small></p> <p><input type="checkbox"/> Genetic Testing Initial: _____ Date: _____</p> <p><input type="checkbox"/> Drug/Alcohol Initial: _____ Date: _____</p> <p><input type="checkbox"/> HIV Initial: _____ Date: _____</p> <p><input type="checkbox"/> Mental Health/ Developmental Disability Initial: _____ Date: _____</p> <p><small>*Witness signature required on page 2.</small></p>



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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:

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 representative's identity is required for mental health/developmental disability, 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.)

Witness Signature

Date: _____

PRINT Witness Name

Phone #: _____

State Relationship to Patient