RUSH

Authorized Relative Certification

Affix Patient Sticker Here

AUTHORIZED RELATIVE CERTIFICATION FOR DECEASED PATIENT

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 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.

DECEASED INFORMATION:

Name of Deceased : _____ Maiden Name:_____ Birthdate ___/___/___
Last Name, First Name, Middle Initial

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 will be billed)

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

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

PURPOSE:

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

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

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

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:_____

*Witness signature required on page 2.

Affix Patient Sticker Here

AUTHORIZED RELATIVE CERTIFICATION FOR DECEASED PATIENT

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

☐ I certify that there is no surviving spouse and my relationship to the deceased is (check one):

- ☐ An adult son or daughter of the deceased.
- ☐ A parent of the deceased.
- ☐ 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 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 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 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. 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 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 dates beyond the date of signature. This authorization will expire ninety (90) calendar days after the date of signature.

*(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 Printed Name

_____ _____
Authorized Relative's Address — State Relationship to Deceased

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

_____ Date: _____
Witness Signature

_____ Phone #:_____
Witness's Printed Name

_____
State Relationship to Deceased