RUSH

HIM ROI Authorization

Affix Patient Sticker Here

REPRODUCTIVE HEALTH CARE ATTESTATION

INSTRUCTIONS: 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 Aurora Surgery Center ☐ Rush Medical Group

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

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

RELEASE REQUESTED MEDICAL INFORMATION TO: *(Example: name of investigator and/or agency making request)*

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

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

Description of medical information being requested: (Must indicate specific dates/date range and record content to be included)

_____

_____

_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

I attest that the use or disclosure of PHI I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of PHI is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

I understand I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual, including falsely verifying that the use or disclosure is not for a prohibited purpose, or disclose individually identifiable health information to another person.

REQUESTOR / REPRESENTATIVE SIGNATURE:

_____ _____ _____
Signature of Requestor / Representative Date Time

_____
Print Requestor / Representative Name

_____
Title of Requestor / Authority of Requestor Representative

_____ _____
Agency / Organization Phone Number