Patient Name: ______________________________

Date of Birth: ______________________________

Medical Record #: ___________________________

RUSH SurgiCenter

AUTHORIZATION FOR RELEASE OF PATIENT 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 SurgiCenter, ATTN: Medical Records Department, 1725 W Harrison St. Suite 556, Chicago, IL 60612.** This form must be completed in its entirety.

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)

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 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): ______________________________

DATES:

From: _____/_____/_____ To: _____/_____/_____

REQUESTED MEDICAL INFORMATION:

___Entire Medical Record

___Report of Procedure

___Lab Reports

___History and Physical

___Billing Statement/Claim

__ Discharge Summary

__ Radiology __ Images __ Reports

__ Pathology Reports

__ Other, please specify:______________________________

Patient Name: ______________________

Date of Birth: ______________________

Medical Record #: ______________________

RUSH SurgiCenter

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

This authorization is voluntary. SurgiCenter will not condition your treatment on giving this authorization. However, SurgiCenter 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 SurgiCenter took in reliance in this authorization before SurgiCenter 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 SurgiCenter 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 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 SurgiCenter. I understand that, by signing this form, I am confirming my authorization that SurgiCenter 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: ______________________

Phone # ______________________

____
PRINT Witness name

____
State relationship to patient