

FRANCISCAN ST. MARGARET HEALTH NORTH
5454 HOHMAN AVE
HAMMOND, IN 46320

FRANCISCAN ST. MARGARET HEALTH SOUTH
24 E JOLIET ST
DYER, IN 46311

I AUTHORIZE FRANCISCAN ST. MARGARET HEALTH TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (*Please Print*): _____

Patient Address: _____

Date of Birth: _____ Last 4 Digits of Social Security #: _____ Patient Telephone #: _____

Covering the period(s) of treatment: _____

INFORMATION TO BE RELEASED:

_____ Discharge Summary	_____ Radiology (X-ray, CT Scan, MRI)	_____ ER record
_____ History & Physical	_____ EKG	_____ Lab Results
_____ Operative Report	_____ Consultations	_____ UB04
_____ Complete Health Record	_____ Other (specify): _____	

INFORMATION TO BE RELEASED TO:

Name: **RECORDS DEPOSITION SERVICE, INC.**

Address: **120 W. MADISON STREET, STE. 300**

City, State, Zip: **CHICAGO, IL 60602**

Telephone #: **P: 312-553-8900 F: 312-553-8901**

PURPOSE OF DISCLOSURE: _____ Continuation of Care _____ Insurance _____ Attorney _____ Personal Use Other
For Discovery Before Trial

I understand this authorization can be revoked by me at any time in writing to (*facility Name*) except that disclosure made in good faith has already occurred in reliance on this authorization. (*facility name*) will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you on electronic media that meets the HIPAA and HITECH requirements, you must initial here: _____
The password for accessing your electronic media is: _____

I understand that this release also pertains to records regarding the testing and treatment for **alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here:** _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT, if other than patient: _____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable): _____

WITNESS SIGNATURE: _____ DATE: _____

