Loretto Hospital

645 S Central Ave.
Chicago, IL 60644

REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

Use this form to request a copy of your medical records. In order for Loretto Hospital to respond promptly and accurately to your Authorization, please complete this form in its entirety.

Patient Last Name:	Patient First Name:	Patient Middle Name:
Birthdate:	Social Security Number:	Medical Record Number:

Address:			
City:	State:	Zip:	Phone:

INFORMATION REQUESTED.
I authorize Loretto Hospital to use or disclose the following health information during the term of this Authorization: **Check all that apply.**

- ☐ Summary, including Hospitalization (History and Physical, Consultations, Surgical, Discharge Summary)
- ☐ APEC/CDU Discharge Summary
- ☐ Complete Medical Record
- ☐ Clinical Visit Notes
- ☐ EEG
- ☐ EKG
- ☐ Emergency Room Record
- ☐ Face Sheet (Identifying Information)
- ☐ Laboratory Results
- ☐ Occupational Therapy / Physical Therapy Record
- ☐ Operative Report
- ☐ Outpatient Record Summary
- ☐ Pathology Report
- ☐ Pharmacy Records
- ☐ Radiology Images
- ☐ Respiratory Therapy Record
- ☐ Therapy Notes (please specify) _____
- ☐ X-Ray Results
- ☐ Other (please specify) _____

For the following dates of treatment: (For example: list a Specific Date 1/25/09; or a Range of Dates: Jan-Aug 2007; or All Dates of service)

SPECIAL CONSENT SECTION.
Pease note if the below is not completed, this information will not be released. **Check and initial all that apply.**

I specifically authorize the disclosure of information relating to:

- ☐ Substance (i.e. Drug or Alcohol) Abuse _____ (Initial)
- ☐ A Mental Illness or Developmental Disability _____ (Initial)
- ☐ HIV/AIDS Testing or Treatment _____ (Initial)
- ☐ Sexually Transmitted Infections _____ (Initial)
- ☐ Psychotherapy Notes (which are not part of the medical record) _____ (Initial)
- ☐ Sexual Assault _____ (Initial)
- ☐ Child Abuse and Neglect _____ (Initial)
- ☐ Genetic Testing _____ (Initial)
- ☐ Abuse of an Adult with a Disability _____ (Initial)

RECIPIENT AND PURPOSE: To you or to the person/company (For example: Insurance Company, School, Physician, etc.)
I request that this information be released to the following individual or agency:

Name of Individual Receiving Information:	Phone Number:
VICTORIA RICHMOND	(248) 357-3330

Name of Organization: RECORDS DEPOSITION SERVICE

Address: P.O. BOX 5054

City:	State:	Zip:
SOUTHFIELD	MI	48086-5054

The Purpose of the Disclosure:
☐ My Personal Use ☐ Sharing with a Healthcare Provider ☑ Other (Please specify): LEGAL DISCOVERY BEFORE TRIAL

Delivery Method:
☐ Pick Up in Person ☐ US Mail ☑ Other (please specify): E-MAIL TO: INFO@RECDEP.COM

TERM: Unless a box below is checked, this Authorization will expire when the request is fulfilled.

- ☐ From the date of this Authorization until: _____
- ☐ Until the; following event occurs: _____
- ☐ Other (please specify): _____

NOTE: For mental health records, the term must be stated, you may NOT use "No Expiration"

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REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Name:

BY SIGNING THIS AUTHORIZATION FORM, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:

- I understand that I have the right to change my mind and that I may revoke this authorization at anytime by notifying Loretto Hospital Medical Records Department in writing. Such revocation shall have no effect on disclosures made prior to the revocation. Written revocations may be sent to: Loretto Hospital, Medical Records Department, 645 South Central Avenue, Chicago, Illinois 60644.
- I understand that once my health information has been disclosed to the recipient, Loretto Hospital cannot guarantee that the recipient will not re-disclose my health information to a third party as required by law. The third party may not be required to comply with this Authorization or federal privacy laws.
- I understand that if I have questions about disclosure of my protected health information, I may contact the Medical Records Department at Loretto Hospital at 773-854-5370.
- I understand that I have the right to inspect and copy any information disclosed under this Authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information.

I HEREBY AUTHORIZE LORETTO HOSPITAL TO RELEASE TO THE ABOVE INSTITUTION / INDIVIDUAL MY HEALTH INFORMATION FOR THE PURPOSE IN WHICH I HAVE DESIGNATED IN THE MANNER DESCRIBED ABOVE.

Signature of Patient — Date / Time

Signature of Personal Representative — Date / Time

Name of Personal Representative & Relationship to Patient

****NOTE: Patients must have a valid Photo ID to get their records.****

E-Mail Consent

I give permission for my records to be sent to me via e-mail. I realize that there may be some security risks to my private health information because it will NOT be sent to me in an encrypted form. My signature below indicates that I accept the risk associated with unencrypted mail and hold Loretto Hospital, its employees, agents and board members harmless for any damages I may experience related to this transmittal. I understand that I have other choices as to how I can receive my private health information and I choose to have it emailed to me.

E-Mail Address INFO@RECDEP.COM

Signature of Patient — Date / Time

Signature of Personal Representative — Date / Time

Name of Personal Representative & Relationship to Patient

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