☐ Pick up
☐ Mail
☐ Fax to physician only

# Palos Health

12251 South 80th Avenue • Palos Heights, Illinois 60463 • 708.923.4664

## Authorization to Release Medical Information

**PMG Physician** ______________________ **Office Number** __________________ **Fax Number** __________________

**FOR HOSPITAL USE ONLY**

☐ I request and authorize _________________________________ to disclose my health information to Palos Health.
(other institution)

Records release by: ______________ Request taken by: ____________________ Medical Record # __________________
Date ____________ Time __________ Date ______________ Time ____________
☐ Copy to Radiology
☐ Copy sent to Lab
☐ Copy sent to ____________________

***Please complete all boxed areas that apply.***

Patient Name ______________________________________________________________
Last First Middle Initial
Address _____________________________________________ Apt # ____________________
City ______________________ State ____________ Zip ___________ Day Phone # __________________
Birthdate ____________________ Evening Phone # __________________

***Do you give permission for Health Information Management to leave the message on your voice mail or answering machine?*** ☐ Yes _______ ☐ No _______ (please check and initial)

**If I can't personally pick up the records you may release the copies to:** ________________________________

**I request and authorize Palos Health to disclose my health information to the following:**
***(If same as above, please skip this section.)***

Name RECORDS DEPOSITION SERVICE Power of Attorney? ☐ Yes ☐ No
Address PO BOX 5054 Suite ____________________
City SOUTHFIELD State MI Zip 48086-5054 Office Phone # 248-357-3330
Dr. Fax # ____________________ Appt. Date ______________________ Attention ______________________
The information for which I am authorizing will be used for the following purpose:
☐ Personal ☐ Medical ☒ Legal ☐ Insurance ☐ School ☐ Court ☐ Employer ☐ Other _______________

***DATES OF SERVICE TO BE RELEASED:*** **From:** _____ / _____ / _____ **To:** _____ / _____ / _____

***The type of information requested is as follows:***

☐ Inpatient chart
☐ Entire chart ***(OR)***
☐ Diagnostic abstract
☐ Emergency Department
☐ Outpatient
☐ Immediate Care
☐ Palos Medical Group (PMG)
☐ Discharge summary
☐ EKG
☐ Lab results
☐ Pathology report only
☐ Pathology slides
☐ Physical Therapy
☐ Stress test
☐ Surgical reports
☐ X-ray report
☐ X-ray films/CDs
☐ ECHO Disk
☐ Cardiac Cath Disk
☐ Other _______________
☐ _______________
☐ _______________
☐ _______________

**Behavioral Health and Other Sensitive Health Information**

**SPECIFIC CONSENT** By checking any of the boxes below, I am specifically authorizing the Palos Health to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.

**DATES OF SERVICE TO BE RELEASED: From:** ___/___/____ **To:** ____/____/____ (if no end date is entered, the end date will be the day of discharge)

☐ AIDS/related illness, diagnosis/treatment ☐ Genetic testing ☐ HIV test results ☐ Sexually transmitted disease



***Turn over to complete form***

**Psychiatric/mental health or developmental disabilities information:**

☐ All my psychiatric/mental health or developmental disabilities records ☐ Family participation ☐ Emergency contact only
☐ Discharge planning ☐ Other ________________________________________________

**Substance abuse (i.e., alcohol or drug) information:**

☐ All my substance use disorder records ☐ Family participation/Opioid agreement/Disulfiram agreement
☐ Drug screen results ☐ Emergency contact only ☐ Discharge planning ☐ Other ______________________________

**Psychiatric/mental health or developmental disabilities information:**

This information has been disclosed to you from records protected by federal confidentiality rules ( 42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocations will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on ___________________________ (please insert a date or event). If I fail to supply an expiration date or event, this authorization will expire ninety (90) days from the date it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

***Signature of patient or legal representative*** _______________________________ Date _______________

***If signed by a legal representative, relationship to patient*** ______________________ Date _______________

***Signature of witness*** ____________________________________________ Date _______________

## This Section is for Release of Original Slides, Mammograms and/or Photos

***The following information must be completed before Pathology slides are released:***

☐ Slides will be picked up **OR** ☐ Slides should be sent to physician ________________________________

Physician's Phone Number

________________________________________

Physician and Facility Name (reviewing material)

________________________________________

Physician's Fax Number (optional)

________________________________________

Address

________________________________________

City State Zip Code

All slides, original photos, films or specimens or other materials used in my care (Diagnostic) remain hospital property and are being released only at patient's request to serve the patient's interest. I understand that I am responsible for the return of the Diagnostic Property to Health Information Management within fourteen (14) days. If the Diagnostic Property is not returned to the Hospital, I hereby agree to indemnify the Hospital, its employees, physicians and agents for payment of all claims, demands, settlements, or judgments, costs and expenses that result from, are caused by or are related to the Hospital's inability to defend said claim, demand or lawsuit due to its inability to produce or review the diagnostic property. This indemnification shall bind me, my heirs, legal representatives and assigns. I also understand that this will constitute an incomplete medical record, which may compromise my future care and/or treatment and I accept responsibility for any adverse outcome that may result due to any future release by Hospital of such incomplete records.

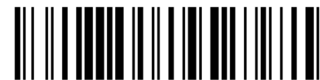
I understand that if I have authorized the permanent release or transfer of any of the Diagnostic Property, to another health care facility, it is my responsibility to track the location of this property.

________________________________________ ________________________

Patient Signature Date

________________________________________ ________________________

Legal Representative's Signature/Relationship Date



AUTHROI

## This Section is for Nursing Units for Patients Being Discharged

**Send this form to Health Information Management, attention R.O.I., after patient completes and signs form.**

☐ HIM to copy indicated chart forms for release to patient/family member.