Presence
Mercy Medical Center

1325 North Highland Ave.
Aurora, IL 60506

Side 1

Authorization to Use and Disclose Health Information

Patient's Name: ______________________ **Date of Birth:** __________ **Telephone Number:** ( )______________

Medical Record Number: ______________________

I hereby authorize the use and disclosure of the individually identifiable health information about me that is described below by Presence Health for the specific purposes listed below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below, and that Presence Health is not receiving any remuneration from any third parties as a result of this use or disclosure of information. I understand that Presence Health may not and will not condition health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits, upon my signing this authorization for the requested use and disclosure. I further understand that if the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In such a case, the information may be redisclosed by the recipient to others for other purposes. I understand that I may, at any time, inspect or obtain a copy of the information about me that will be used and disclosed, as described below, by mailing a written request to, or presenting it in person at, any Presence Health facility.

Release the Following Information:

- ☐ Discharge Summary
- ☐ Pathology Report(s)
- ☐ Emergency Record(s)
- ☐ History and Physical
- ☐ Abstract (Document Summarizing Health History and Pertinent Information)
- ☐ Social History
- ☐ Radiology Report(s)
- ☐ Itemized Billing Statement
- ☐ Consultation(s)
- ☐ Lab Report(s)
- ☐ PT/OT/SPEECH
- ☐ Operative Report(s)
- ☐ Cardiology Report(s)
- ☐ Progress Notes
- ☐ Treatment Plan(s)
- ☐ Psych Evaluation
- ■ Other Records as specified: SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED
- ☐ Discharge Medication List
- ☐ Entire Medical Record (Except for Records Concerning Highly Confidential Information mentioned below)
- ☐ Films/CD

I also authorize the release of the following: ☐ Alcohol/Drug abuse diagnoses and treatment records

☐ Records of HIV/Aids testing, diagnose or treatment ☐ Mental Health records ☐ Genetic (check all that apply)

Approximate dates of treatment: ______________________
From ______________ to ______________

Purpose of the use or disclosure: FOR DISCOVERY BEFORE TRIAL
(further care, insurance claim, attorney inquiry, at the request of the individual, personal use, etc,)

Persons or organizations using or disclosing the information: RECORDS DEPOSITION SERVICE, INC.

Persons or organizations receiving the information and address: 120 W. MADISON ST., SUITE 300, CHICAGO, IL 60602
P: 312-553-8900 F:312-553-8901

I understand that my decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and that I may refuse to sign this form. I understand that I may revoke this authorization, in writing, at any time. However, such a revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law. I may make such a written revocation by mailing it to, or presenting it in person at, any Presence Health facility. I also understand that I may request a copy of Presence Health's Notice of Privacy Practices, or ask any other questions, by calling Presence Health's **AlertLine**, at **1-800-93-ALERT**, or the Health Information Management Department of the Presence Health facility where I receive treatment, at any time, in order to learn more about how information about me is used or disclosed by Presence Health or about revocation of this authorization. Unless revoked by me sooner or limited or restricted to a shorter time period by applicable law, this authorization shall be effective for 90 days after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below, and if signing in person at a Presence Health facility, I will ask for such a copy, if one is not provided, before I leave.

***Notice to Recipients of Alcohol & Drug Abuse Information:**
The confidentiality of alcohol and drug abuse patient records maintained by Presence Health, and disclosed to you pursuant to this under this authorization, is protected by Federal law and regulations (*see* 42 U.S.C. § 290dd-3 and 290ee-3, and 42 C.F.R. pt. 2). Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime. Suspected violations should be promptly reported to appropriate authorities, in accordance with Federal regulations. Federal laws and regulations do not protect any information about a crime committed by a patient or about any threat to commit a crime. Federal laws and regulations also do not protect information about suspected child abuse or neglect from being reported under State law or regulations to the appropriate State or local authorities.

I accept these terms and authorize the above use and disclosure:

____ ______________
Signature of Patient or Legally Authorized Representative *Date*

______________________________ ______________________ ______________
If not Patient, then Relationship of Legally Authorized Representative to Patient *Signature of Witness* *Date*

(Spanish version on back side)