MRN:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name (*Please Print*)________________ Maiden Name or AKA________________

Address ________________ Birthdate ________________

City/State/Zip________________ Phone #________________

I AUTHORIZE the Mercyhealth entity checked below:

☐ **Rockford Memorial Hospital** 2400 N. Rockton Ave., Rockford, IL 61103 815-971-2710

☐ **Rockford Health Physicians** (Indicate office site(s):________________

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☐ **Mercyhealth at Home** 4223 E. State St. Rockford, IL 61108 815-971-3550

☐ **To Release Records to:** ☐ **To Receive Records from:**

RECORDS DEPOSITION SERVICE, INC.
(Name of Health Care Facility, Individual, Agency, etc.)

PO BOX 5054
(Address)

SOUTHFIELD,MI, 48086-5054
(City/State/Zip)

Phone: 248-357-3330 Fax: 248-357-3337

Records from the following timeframe:________________

What is Needed:

☐ Abstract (includes p*hysician reports, procedure reports, and test results such as lab and radiology)*
☐ Entire Record
☐ Emergency Department Record
☐ Immunization Record
☐ Lab
☐ Imaging Reports ☐ Imaging CD from Radiology
☒ Other (describe what is needed): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

THE PURPOSE OF THIS DISCLOSURE OF INFORMATION IS:

☐ Continuing Care ☐ Disability Determination ☐ Insurance ☐ Legal ☐ Personal ☒ Other PRE TRIAL DISCOVERY

- I understand that my medical 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, developmental disabilities, treatment for alcohol and/or drug abuse, or genetic testing.**
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I may contact the Director of Health Information Services for questions regarding disclosure of my health information.
- I understand that my refusal to consent to the release of the above mentioned information will prevent the disclosure of the information.
- I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency. If I refuse to authorize release of information for this purpose, it may adversely affect my entitlement to insurance benefits.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date or event:________________. If I do not specify an expiration date or event, this authorization will expire in six months.

________________ Date: ________________
Signature of Patient or Legal Representative

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If Signed by Other than the Patient, State Relationship

________________ Date: ________________
Witness

-Illinois Mental Health & Developmental Disabilities Confidentiality Act, Ch. 91 1/2, par. 804 - Minors ages 12-17 years old: patient, parent/legal guardian, and witness must sign and date.
-Minors 12-17 years old may authorize the release of alcohol and/or drug abuse information (Federal Regulations 42CFR).

Original: Medical Record
Copy: Patient