TRINITY MEDICAL CENTER
IOWA HEALTH SYSTEM

AUTHORIZATION
FOR RELEASE OF MEDICAL INFORMATION

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Trinity Regional Health System. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Trinity Regional Health System, I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations.

INSTRUCTIONS:	**Make sure all blanks are filled in. Failure to do so could prevent or delay processing.**
PATIENT IDENTIFICATION	Name (Legal/Maiden/Other) _____ Address (inc.city/state/zip) _____ Phone Number(s) _____ Date of Birth: _____ Soc. Sec.: _____ Parents/Previous Names: _____
PROVIDER (Who is releasing the information)	Provider Name: **TRINITY HOSPITAL – ROCK ISLAND** Address (inc.city/state/zip) **2701 17TH STREET, ROCK ISLAND IL 61201**
REQUESTOR: (Where do you want the information sent)	Requestor Name: **RECORDS DEPOSITION SERVICE, INC.** Address (inc. city/state/zip) **120 W. MADISON STREET, STE. 300, CHICAGO, IL 60602**
INFORMATION REQUESTED:	Service Dates: _____ ___ Entire record ___ Abstract (all physician dictations/test results) __X__ Other, please specify **PLEASE SEE ENCLOSED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED.**
PURPOSE OF RELEASE:	___ Continuing Medical Care ___ Insurance Coverage __X__ Legal proceedings ___ Other: Specify: _____

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

PATIENT OR
LEGAL REPRESENTATIVE SIGNATURE: _____ Date: _____

RELATIONSHIP TO PATIENT
IF NOT SIGNED BY PATIENT: _____ Date _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW

I specifically authorize the release of data and information relating to (indicate YES/NO for each):

_____ Substance Abuse (Alcohol/Drug)

_____ Mental Health (includes psychological tests)

_____ HIV related (AIDS related testing)

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirement (IL LAW) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

PATIENT (Minor's signature required if ages 12-17) OR
LEGAL REPRESENTATIVE SIGNATURE: _____ Date: _____

RELATIONSHIP TO PATIENT IF NOT SIGNED BY PATIENT: _____ Date _____

WITNESS SIGNATURE: _____ Date _____

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A copy of this signed authorization will be provided to the patient.