CentegraHealthSystem

AUTHORIZATION FOR DISCLOSURE HEALTH INFORMATION MEDICAL RECORDS

PATIENT NAME _____ MRN _____
LAST FIRST MIDDLE INITIAL

DATE OF BIRTH _____ TELEPHONE _____
MM/DD/YY

The undersigned hereby authorizes and requests:

Centegra Memorial Medical Center
INSTITUTION OR INDIVIDUAL
3701 Doty Road
STREET ADDRESS
Woodstock, IL 60098
CITY STATE ZIP CODE

to furnish to:

Records Deposition Service, Inc.
INSTITUTION, INDIVIDUAL, OR AGENCY
120 W. Madison St., Suite 300
STREET ADDRESS
Chicago, IL 60602
CITY STATE ZIP CODE
Phone: 312-553-8900 Fax: 312-553-8901

Information contained in my healthcare record for review, examination, and/or photocopies. Access to this information is limited as designated below:

TYPE OF HEALTHCARE ENCOUNTER: _____ **DATE (S): From:**_____ **To:**_____*

Release only those portions of the medical record checked below: Entire medical record: X Films:( )_____

Abstract: ( ) Other: ( ) Please Specify:_____

The purpose/need for the record/information is: Pre-trial Discovery
(e.g., further care, insurance claim, legal counsel, etc.)

I fully understand the following: My medical record and/or information in connection with the hospitalization / treatment date(s) stated above may contain mental health and developmental disabilities, alcohol or drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results and/or information. The medical records and/or healthcare information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and may not be covered by law. Centegra Health System is not responsible for any redisclosures of health information or medical records. I may inspect and arrange for photocopies of the information records/healthcare that are to be disclosed.

THIS AUTHORIZATION EXPIRES ONE (1) YEAR FROM THE DATE OF SIGNATURE.
I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the CHS facility where I signed my authorization. If I refuse to sign this authorization, my medical records/health information will not be released. I understand that if this authorization is for the purposes of third party payment to Centegra Health System that diagnostic and therapeutic information as may be necessary to process benefits will be disclosed to my insurance company and/or the insurance company s review agency, and that refusal to authorize information for this purpose will result in the assignment of financial responsibility to me for these services. No other adverse consequences to me will result if I refuse to sign this authorization.

PATIENT/AUTHORIZED SIGNATURE _____ DATE _____
(if other than patient, state relationship)

WITNESS SIGNATURE _____ DATE _____