OSF HEALTHCARE

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

MUST COMPLETE ALL BLANK LINES

PATIENT INFORMATION	Patient Name:_____ Address:_____ City, State, Zip Code:_____ Phone Number: _(____)_____ Date of Birth: _____
PROVIDER/ORGANIZATION: (Who is authorized to release your information)	**I hereby authorize:** Name: _____ Address: _____City, State, Zip Code:_____ Phone Number: _(____)_____
REQUESTOR: (To whom you want your information to go)	**To Release my medical records to:** Name: Records Deposition Service Address: P.O. Box 5054 City, State, Zip Code: Southfield, MI 48086-5054 Phone Number: (248) 357-3330 Fax Number: (248) 357-3337
Disclose Records to	☐ OSF MyChart ☐ CD (mailed to address above) ☐ Paper (mailed to address above) ☒ Encrypted Email requests@recdep.com
PURPOSE	☐ Continuing Care ☐ Insurance ☒ Legal ☐ Personal ☐ Other _____
INFORMATION TO BE DISCLOSED:	☐ Abstract ☐ Entire Medical Record ☐ Lab Results ☐ Radiology Results ☐ Imaging Films ☐ Medical Bills ☐ Other (please be specific): _____ Date(s) of Visit: _____

HIGHLY CONFIDENTIAL INFORMATION

It is my full understanding that the records and communications to be disclosed WILL include Highly confidential information such as HIV/AIDS, drug and alcohol abuse, sexually transmitted disease, genetic testing, and mental health information. If you want to have any of this information excluded, check below.

☐ **Alcohol/Substance Abuse** ☐ **Mental Health** ☐ **Developmental Disabilities** ☐ **HIV/AIDS** ☐ **Genetic Testing**
☐ **Other:** _____

By signing below,

- I understand that this authorization is **voluntary**, and I can refuse to sign this authorization. I understand that person(s) or organization(s) may **NOT** condition my **treatment, payment or enrollment** based on my signature on this authorization.
- I understand any disclosure of information carries with it the **potential for an unauthorized re-disclosure** and once the information is re-disclosed it **may not be protected** by the HIPAA privacy rule.
- I understand I have **the right to revoke** this authorization at any time. If I revoke this authorization I must do so in writing to the Health Information Department of the OSF Healthcare Facility listed above under Provider/Organization. I understand that the revocation will not apply to information that has already been disclosed in response to this release.
- I understand I have the right to inspect and copy the information to be disclosed.
- I understand this authorization will **expire 1 year from the date of the signature** below or **upon a date, event or condition that I am specifying here:** _____

_____ _____
Signature of Patient or Patient Representative ***Date***

_____ _____
Signature of Child (12-17) for MHDDCA purposes only ***Date***
405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act

_____
Signed by Patient Representative print name, state relationship to patient and provide evidence of Authority to act for individual