Ingalls.
Memorial Hospital
One Ingalls Drive, Harvey, Illinois 60426 (708) 333-2300

AUTHORIZATION FOR RELEASE OF INFORMATION

Section I: Patient Information

Patient Name:____________________ Address:____________________ City/State/Zip:________________

Date of Birth_____/_____/_____ Phone ( ) ____________________

Section II: Recipient and Purpose

I,______________________________, hereby authorize Ingalls Memorial Hospital to release my medical records to:

Agency/Facility/Person:____

Address:______________________________ City/State/Zip:____________________

These records are to be released for the purpose of *(Check all that apply)*:

☐ Continuity of Care ☐ Attorney/Client Relationship ☐ Insurance ☐ Patient's Personal Need

Section III: Information Requested

I authorize Ingalls Memorial Hospital to use or disclose the following health information during the term of this authorization:

(Check all that apply):

☐ Occupational Medicine ☐ Therapy Notes (PT, OT, Speech, etc) ☐ Emergency Room Record (IMH, Tinley Park, Flossmoor, Calumet City)

☐ Test Results (Specify: Lab, X-ray, EKG, etc.) ____________________ ☐ Radiology Films ☐ Cardiology Films

☐ Specific Report (Specify: Discharge Summary, H&P, Consult, Surgical, etc.) ______________________________

☐ Record Abstract (Discharge Summary, History & Physical, Consults, Operative Report, Pathology Report, Lab, Radiology, other diagnostic reports & ER, if applicable)

☐ Complete Medical Record ☐ Other (Please specify):______________________________

Dates of treatment to be released: (For example: specific date 1/1/04; range of dates Jan - Jun 2003; all dates of service)

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I understand that these documents may include sensitive information such as mental health/psychiatric illness, HIV/AIDS, or treatment for substance or alcohol abuse. I consent to the release of these documents. *(Check all that apply)*:

☐ Mental Health/Psychiatric Illness ☐ HIV/AIDS ☐ Substance or alcohol abuse*

*Federal regulations require a description of how much and what kind of information is to be disclosed. Please describe:
(For example: drug or alcohol diagnosis; treatment; referral information)

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I understand that my records are protected under the Federal and Illinois laws and cannot be disclosed without my written consent unless otherwise provided by law.

I UNDERSTAND that I have the right to revoke this consent at any time by submitting a written and dated notice for revocation to the facility releasing this information. This authorization expires on (specify date or event) ________________. For mental health records, if no date is specified, this authorization will automatically expire ninety (90) days from the date signed below.

______________________________ ________________
Signature of Patient or Legally Authorized Person — Date of Signature

______________________________ ________________
Legal relationship to Patient, if signature not of Patient/Client

______________________________ ________________
Signature of Witness, if applicable — Date of Signature

NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the AIDS Confidentiality Act, you may not redisclose any mental health, substance abuse or HIV/AIDS related information unless the person who consented to this disclosure specifically consents to such redisclosure. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.