



INSTRUCTIONS: This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

SECTION 1 - Patient Information			
Patient Full Name - First, Middle, Last:		Birthdate: Month _____ Day _____ Year _____	
Patient Address - Street/Apt/Suite:		City:	State: _____ Zip: _____
Phone Number:	Fax Number:	Social Security Number (Last 4) XXX-XX-____	OFFICE USE ONLY: Patient MRN/Encounter Number

SECTION 2 - Disclosure of Health Information			
I authorize <u>Ascension Heart and Vascular</u> to <input checked="" type="checkbox"/> Disclose <input type="checkbox"/> Obtain <input type="checkbox"/> Disclose and Obtain			
Disclose To (facility name)			
Name of Facility/Entity/Individual: <u>Illinois Cardiovascular Specialists</u>			
Street Address/Apt/Suite: <u>350 E. Congress Pkwy, Unit E</u>		City: <u>Crystal Lake</u>	State: <u>IL</u> Zip: <u>60014</u>
Phone Number: <u>815-477-8900</u>		Fax Number: <u>815-477-7160</u>	

Obtain From			
Name of Facility/Entity/Individual: <u>Ascension Medical Group Heart and Vascular - David Bromet, MD</u>			
Street Address/Apt/Suite: <u>2971 W. Algonquin Rd, Ste 106</u>		City: <u>Algonquin</u>	State: <u>IL</u> Zip: _____
Phone Number: <u>847-717-0600</u>		For Direct Patient Care Only - Fax Number: <u>847-854-3225</u>	

SECTION 3 - Purpose Of Disclosure			
<input type="checkbox"/> Legal	<input type="checkbox"/> School	<input type="checkbox"/> Further Care/Treatment	<input checked="" type="checkbox"/> Transfer/Placement
<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Other (specify) _____	

SECTION 4 - Requested Format			
<input checked="" type="checkbox"/> Paper	<input type="checkbox"/> Electronic Media	<input checked="" type="checkbox"/> Fax	<input type="checkbox"/> Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 5 - Delivery Method			
<input type="checkbox"/> Mail	<input type="checkbox"/> Pick-Up	<input type="checkbox"/> Secure Email (email address) _____	<input type="checkbox"/> Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 6 - Dates of Treatment			
Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017): <u>2/1/22 - Present</u>			

SECTION 7 - Medical/Surgical Health Information To Be Disclosed - Check All That Apply			
<input checked="" type="checkbox"/> Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests).			
<input type="checkbox"/> Emergency Report	<input checked="" type="checkbox"/> Clinic Notes (specify clinic) _____		
<input checked="" type="checkbox"/> History and Physical(s)	<input type="checkbox"/> Rehab or Therapy Notes (specify type) _____		
<input checked="" type="checkbox"/> Consultation(s)	<input type="checkbox"/> Prenatal Summary _____		
<input checked="" type="checkbox"/> Progress Note(s)	<input type="checkbox"/> Entire Chart		
<input checked="" type="checkbox"/> Operative/Procedure Report(s)	<input type="checkbox"/> Itemized Bill		
<input checked="" type="checkbox"/> Laboratory Results	<input checked="" type="checkbox"/> Other (specify) <u>Face Sheet</u>		
<input type="checkbox"/> Pathology Results	<input type="checkbox"/> Discharge Summary		
<input checked="" type="checkbox"/> Radiology Report(s)			
<input type="checkbox"/> Radiology films/digital images			
<input checked="" type="checkbox"/> EKG/Stress Test(s)			

Authorization for Release of Patient Health Information



Place Label Here

SECTION 8 – Specific Consent MUST BE COMPLETED FOR ALL REQUESTS

If any of the highly confidential information listed below is contained in the medical records requested, I am specifically authorizing the use and/or disclosure of this information by checking the boxes below, if applicable to this authorization.

- Information about Mental/Behavioral Care and Treatment
- Information about Substance Abuse Care and Treatment
- Information about Psychological Testing
- Information about HIV/AIDS Testing or Treatment
- Pregnancy (the patient 12 or over must authorize this release)
- Information about Sexually Transmitted Disease(s)
- Information about Genetic Testing, *Cardiac Only*
- Information about Sexual Assault/Abuse
- Information about Child Abuse and Neglect
- Not Applicable to this authorization

SECTION 9 – Behavior Health/Substance Use Disorder Treatment Information To Be Disclosed

Behavioral/Substance Abuse Health Information To Be Disclosed – Check All That Apply

- Inpatient Stay: An abstract of the record will be provided, which includes Test Results, History and Physical, Psychiatric Evaluation, Consultations, Discharge Summary, Face Sheet, unless otherwise specified.
- History & Physical Screen
- Discharge Summary
- Psychiatric Evaluation
- Psychological Testing
- Psychological Evaluation
- Treatment Plan
- Itemized Bill/Insurance
- Other (specify) _____
- Dates of Admission and Discharge
- Progress Notes
- Medication information
- Laboratory Results
- Radiology Results
- Assessment (specify type) _____
- Behavioral/History of Client

Education Department

- Psychiatric Diagnosis
- Medical Diagnosis
- Treatment Information
- Homework Information
- Attendance/Tuition
- CD Diagnosis
- Follow Up Care
- IEP of 504 Plan

SECTION 10 – Authorization Expiration Date

- This authorization is approved for: This occurrence only 60 days from the date of signature
- 1 year from the date of signature (mental health records only) *Only effective for this occurrence if none is chosen.

SECTION 11 – Important Information

I have read and understand the following statements:

Note: If the authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the date the request is received. If this authorization is for medical/surgical or research, an expiration date is not required.

I understand that my health information may be shared with other Ascension Illinois healthcare providers for the purposes of treatment and care coordination.

I understand that I have the right of access to inspect and obtain a copy of my health information.

I understand that I can cancel this authorization at any time by submitting a written notice to the physician office or **Health Information Management Department of the hospital where my health information is stored**. I understand that my cancellation will take effect when the Health Information Management Department receives my written notice.

I understand that my cancellation will not have any effect on health information released before the Health Information Department received my written notice.

I understand that health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

I understand that under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that failure to provide all required information on this authorization form will not constitute a proper authorization to disclose protected health information, including the refusal to sign this authorization and that, therefore, my request may not be honored.

I understand that refusal to sign this authorization will not affect any conditions of my treatment, payment, enrollment, or eligibility for benefits.

SECTION 12 – Signatures

- *Patients 12-17 years of age must sign for Behavioral Health, Substance Abuse, HIV/AIDS, STD, Pregnancy, Birth Control information.
- **Legal Representative or Guardian, please attach a court order or other documentation designating your legal status, as applicable.
- ***Signature of witness who can attest to the identity of the authorized signatory is required to release any mental health or developmental disability information. The witness cannot be the same person as the authorized signatory.

_____/_____/_____
*Signature of Patient

_____/_____/_____
Date

_____/_____/_____
*** Signature of Witness

_____/_____/_____
Date

_____/_____/_____
**Signature of Parent, Legal Representative or Legal Guardian

_____/_____/_____
Date

_____/_____/_____
Relationship of Parent, Legal Representative or Legal Guardian

Place Label Here