Authorization to Disclose Protected Health Information

Patient Name: **Date of Birth:** **Date Information Needed:**

Address:

City: **State:** **Zip:** **Phone#:**

I hereby authorize:
to release the protected health information indicated below on the above mentioned individual to:

Core Orthopedics and Sports Medicine: 555 Biesterfield Road, Elk Grove Village, IL 60007 Phone: 847-690-1776 Fax: 847-690-1777

For the following purpose: ☐ Physician or Health Care Facility ☐ Legal Purposes ☐ Personal Use ☐ At the request of the individual

☐ Other:

For treatment date(s) or service:

Expiration Date or Expiration Event:
(If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days from the date signed below)

INFORMATION TO BE DISCLOSED:

☐ Abstract chart (includes face sheet, Discharge summary, History & Physical, Consultation Reports, Operative Reports, diagnostic tests)

☐ Entire medical record

☐ History and Physical ☐ Consultation ☐ Operative Report ☐ Discharge Summary

Outpatient Services:

☐ Emergency Room ☐ Pathology Report(s) ☐ Laboratory Results ☐ Radiology Results ☐ Rehabilitation Services

☐ Other:

I understand that:

* The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
* I have the right of access to inspect and obtain a copy of my protected health information.
* I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
* Revocation will not apply to information that has already been released in response to this authorization.
* Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
* Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
* Authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

Signature of patient or legal representative: **Date:**

Witness Signature: **Date:**

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient)
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: Date Completed: MR#:
When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative

is authorized to act on behalf of the patient: ☐ Driver's License ☐ Picture ID ☐ Legal Guardian

☐ Court appointed legal guardian ☐ Power of Attorney ☐ Executor of Estate ☐ Other:

Person/Department completing the request:

CORE
ORTHOPEDICS & SPORTS MEDICINE