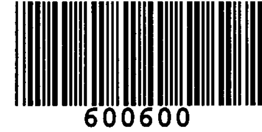
Elmhurst Memorial
Healthcare
Elmhurst, Illinois 60126



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Account Number # ____________________

Written authorization from the patient or legal representative is required by law. All items must be completed to be considered valid.

1. Patient's Name (please print): ______________________ 2. Birth Date: ____ / ____ / ____

3. I authorize the use and/or disclosure of protected health information as described below.

a) Name of person or organization to release the medical record or protected health information (check one):

- ☐ Elmhurst Memorial Hospital -- 155 E. Brush Hill Rd. -- Elmhurst, IL 60126 -- (331) 221-1000
- ☐ Elmhurst Clinic -- 172 Schiller St. -- Elmhurst, IL 60126 -- (630) 834-1120
- ☐ Elmhurst Memorial Home Health -- 855 N.Church Court -- Elmhurst, IL 60126 -- (630) 530-1201
- ☐ Other: ______________________

b) The protected health information will be (check only one):

- ☐ Picked up by patient or their legal representative
- ☐ Faxed (in emergency situations only) to ( ) -
- ☐ Mailed to the address below
- ☐ Reviewed by the patient with a Staff Member Present
- ☐ Other (please specify) ______________________

c) Name of Person/Facility/Agency authorized to receive the PHI:

____

Address: ______________________

City/State/Zip: ______________________

Telephone Number if known: ( ) -

d) Dates of Hospitalization or Service: ______________________

e) Description of PHI to be released (check all that apply):

- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ EKG/Echo
- ☐ Complete Chart
- ☐ History and Physical
- ☐ Immunizations (Clinic Only)
- ☐ Lab Report
- ☐ Operative Report
- ☐ Billing Statements
- ☐ Pathology Report-Case #: ____________
- ☐ PHI Pertaining to Form Completion
- ☐ Progress Notes
- ☐ X-ray Report
- ☐ X-ray films, Photographs, Videotape Digital or other images
- ☐ Other: ______________________

f) Reason as to why this information is to be released (check all that apply):

- ☐ Application for insurance
- ☐ Payment of insurance claim
- ☐ Continuum of care/treatment plan
- ☐ Disability claim
- ☐ Legal
- ☐ Other ____________

4. I understand that the information to be released may include information relating to the diagnosis and/or treatment of acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental and/or behavioral health, drug and/or alcohol abuse. Please exclude the following information:

____

____

____

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5. I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released.
6. I understand that I have a right to inspect and/or receive a copy of the medical information to be released and also receive a copy of this authorization form.
7. I understand that there may be circumstances that would allow Elmhurst Memorial Healthcare to charge a reasonable fee for completing forms and for making copies of the information requested on this authorization.
8. If no prior notice to revoke this authorization is received, this authorization will expire on _____/_____/_____ Date but the expiration date will not exceed 1 year from the date the form is signed.
9. I further understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy confidentiality rules.
10. I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.
11. ____ _____/_____/_____
    Signature of Patient or Legal Representative — Date
12. Relationship to Patient (if other than patient): ☐ Spouse ☐ Parent ☐ Power of Attorney ☐ Other ____________________
13. ____ _____/_____/_____
    Signature of Witness (if applicable) or
    Signature of Staff Member Present During Review — Date

For Registration Use Only

Registrar obtaining consent form ________________________ _____/_____/_____
Signature — Date

ID verified ____ Driver's license _____ State ID ____Passport

Physician entered in Meditech ____ Yes ____ No

For Medical Records Use Only

Medical Record # ________________________

☐ ID Verified ☐ Request completed

Date ____/____ / _____ Completed By ______________________________