Elmhurst Memorial Healthcare
200 Berteau Ave • Elmhurst, Illinois 60126 • 630-833-1400

Authorization to Use or Disclose Protected Health Information (PHI)

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

Account Number: ________________________________

1) Patient's Name (please print):_______________________________________ Birth Date: ____/____/____

2) Patient Address: (please print):____

(Street Address, City, State and Zip Code) ____

(When requesting records from another provider) I authorize:
Name of Person/Facility/Agency ____
to release my protected health information

3) Dates of Hospitalization or Service:____

4) 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
____ Disclosed verbally with the person(s) specified: ___________________________________
____ Other (please specify):____

a) Name of Person/Facility/Agency authorized to receive the PHI: __________________________________
Address: ____
City/State/Zip: ____
Telephone Number if known: ______________________________________

b) What do you need:

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

c). Reason why this information is to be released (check all that apply): ___ Personal copy
____Application for insurance____Payment of insurance claim ____Continuation of care
____Disability claim ____Legal ____FMLA ______________________ Other

5) 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, if possible:
____
____

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Patient's Name (please print):____ Birth Date: ____/____/____

6) 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 to the Medical Record Department. I understand that the revocation will not apply to information that has already been released.

7) This authorization will expire on ___________/__________/___________. Otherwise it will expire one year from this date of authorization.

8) I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.

9) I understand that Elmhurst Memorial Healthcare will charge a fee, as permitted by law, for completing forms and for making copies of the information requested on this authorization.

10) I understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy confidentiality rules.

____ _________________________

Signature of Patient or Legal Representative Date

Relationship to Patient (if other than patient): ____Spouse ____Parent ____Power of Attorney
____Other (specify)

____ _________________________

Signature of Witness (if applicable) or
Signature of Staff Member Present During Review Date

For Registration Use Only

Registrar obtaining consent form ______________________________ _____/______/______.
Date

ID verified _____ ☐ Driver's license _____ ☐ State ID _____☐ Passport
Physician entered in Meditech ______ Yes ______ No

For Medical Records Use Only

Medical Record # ________________________ or Account # ______________________________

☐ ID Verified ☐ Request completed

Date _________/______/________ Completed By ____