Swedish Hospital

Part of NorthShore

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below in this section. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once the authorized organization or person receives this information, then federal privacy laws may no longer protect this information. This authorization shall remain valid for 6 months from date of signing unless revoked.

(1) Patient Name _____ Date of Birth _____

Address_____ Phone _____

(2) Information to be disclosed: From the period(s) dates from _____ to _____

□ Discharge Summary □ Consultation Report □ Pathology Report □ Face Sheet

□ Emergency Services Reports □ History and Physical □ Operative Report □ Nurse Notes

□ Progress/Physician Notes □ Cardiology Reports □Laboratory Reports □ Radiology Reports

□ Diagnosis, Evaluation and/or Treatment for Alcohol and/or Drug Abuse

□ Records of HTLV-II or HIV testing (AIDS test) result, diagnosis, and/or treatment

□ Psychiatric records for mental illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.

□ Other_____

(3) **This information is to be disclosed to:** Person/Institution _____ _____

Address _____ City _____ State _____ Zip _____

For the purpose of :_____

Method of release - **PLEASE CHOOSE ONE ONLY**

□ Electronically on a CD to be **picked up in person** □ Electronically on a CD **mailed to the address** above

□ Fax to Number _____

□ Paper copy to **be picked up in person** □ Paper copy to be **mailed to address above**

Swedish Hospital, its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(4) I understand that I may revoke this consent at any time by giving written notice to: The Medical Records Department at Swedish Hospital, 5145 North California Avenue, Chicago, IL 60625.

(5) I understand I have the right to inspect and copy information being disclosed under this authorization.

(6) I understand that the person receiving the information may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. However, if the person or entity that receives the information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

(7) If I do not sign this authorization, the hospital will not release my information at this time. I understand that if I refuse to sign this authorization, the hospital may not refuse to treat me and will submit claims for services to my health plan.

_____ _____ _____ _____

Signature of Patient/Parent/Guardian/Personal Representative Date Relationship to Patient

XCONROI