850 W. Irving Park Road Chicago, IL 60613-3098 Ph: 773-975-6813 Fax: 773-975-3228

AUTHORIZATION TO DISCLOSE PRIVILEGED
MEDICAL INFORMATION OR REVIEW OF MEDICAL RECORDS

Patient Name: ________________________________ ____________________ __________
Last Name First Name Middle Initial

Date of Birth: _____/_____/_____ Social Security Number: _____________________ Telephone (____) ___________

Description of information that may be disclosed: **Date(s) of Treatment:**

___ INPATIENT ____
___ OUTPATIENT ____
___ EMERGENCY ROOM ____
___ CLINIC ____
___ OUTPATIENT SURGERY ____
___ OUTPATIENT RADIOLOGY (X-Ray) ____
___ OUTPATIENT LABARATORY ____
___ OTHER ________________________ ____

I hereby authorize Thorek Memorial Hospital to: ☐ DISCLOSE TO: ☐ OBTAIN FROM:

Person / Facility ____

Address ____

City, State, Zip ____

I am authorizing Thorek Memorial Hospital to release sensitive information as indicated:

☐ AIDS / HIV ☐ Sexual Assault ☐ Behavioral Health
☐ Drug / Alcohol Abuse ☐ Child Abuse ☐ Developmental Disabilities

This information will be used for the following purpose:

☐ Continuing Care ☐ Personal ☐ Legal ☐ Other _________________________________

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligible for benefits. I understand that I may revoke this authorization at any time by notifying the HIM department in writing. However the revocation will not be valid if (a) Action has been taken in reliance on this authorization, or (b) If the authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

This authorization will expire: ____
(Date, Event or Condition upon which consent expires)

____
Signature of Patient or Legally Authorized Patient Representative Date of Signature

____
Relationship to Patient

____
Signature of Witness Date of Signature