



Palos Community Hospital

12251 S. 80th Avenue • Palos Heights, Illinois 60463 • (708) 923-4664

Authorization To Release Medical Information

FOR HOSPITAL USE ONLY

I request and authorize _____ to disclose my health information to Palos Community Hospital.
(other institution)

Pick up _____ Request taken by: _____ Medical Record # _____
 Fax _____ Date _____ Time _____ Copy to Radiology
 Mail _____ Records release by: _____ Copy sent to Lab
 _____ Copy sent to _____
 _____ Records verified by _____
 _____ Films verified by _____

Please complete all boxed areas that apply.

Patient Name _____
Last _____ First _____ Middle Initial _____
Address _____ Apt # _____
City _____ State _____ Zip _____ Day Phone # _____
Birthdate _____ S.S. # _____ Evening Phone # _____

The information for which I am authorizing disclosure will be used for the following purpose:

Personal Medical Legal Insurance School Court Employer Other _____

It may be necessary to telephone you regarding your authorization. If you are not available, a message identifying the hospital will be left on either your answering machine or with the person answering the phone. Do you give permission for Medical Records to leave the message? Yes _____ No _____ (please check and initial)

If I can't personally pick up the records you may release the copies to: _____

I request and authorize PALOS COMMUNITY HOSPITAL to disclose my health information to the following: *(If same as above, please skip this section.)*

Name _____
Address _____ Suite _____
City _____ State _____ Zip _____ Office Phone # _____
Dr. Fax # _____ Appt. Date _____ Attention _____

DATES OF SERVICE TO BE RELEASED: From: ____ / ____ / ____ To: ____ / ____ / ____

The type of information requested is as follows:

<input type="checkbox"/> Inpatient chart	<input type="checkbox"/> Family Health Center	<input type="checkbox"/> Pathology report	<input type="checkbox"/> _____
<input type="checkbox"/> Entire chart	<input type="checkbox"/> Anesthesia records	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> _____
<input type="checkbox"/> Diagnostic abstract	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Stress test	<input type="checkbox"/> _____
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> EEG	<input type="checkbox"/> Surgical reports	<input type="checkbox"/> _____
<input type="checkbox"/> Outpatient	<input type="checkbox"/> EKG	<input type="checkbox"/> X-ray report	<input type="checkbox"/> _____
<input type="checkbox"/> Primary Care Center	<input type="checkbox"/> EMG	<input type="checkbox"/> Pathology blocks/slides	<input type="checkbox"/> Other _____
<input type="checkbox"/> Palos Immediate Care	<input type="checkbox"/> Lab results	<input type="checkbox"/> X-ray films	<input type="checkbox"/> _____

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 and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record department. I understand that the revocations will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on _____ (please insert a date or event). If I fail to supply an expiration date or event, this authorization will expire 90 days from the date it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature of patient or legal representative _____ Date _____

If signed by a legal representative, relationship to patient _____ Date _____

Signature of witness _____ Date _____

This Section is for Release of Original Slides, Blocks, Mammograms and/or Photos

Slides and/or blocks are being delivered to:

Physician/Facility Name

Original mammography films are being delivered to:

Original photos are being delivered to:

Physician/Facility Address

Physician's Phone Number/Facility Phone Number

Physician's Fax Number

The Slides, Blocks, Original Photos remain hospital property and are being released to serve the patient's interest. I understand that I am responsible for the return of the Slides, Blocks and Original Photos to Medical Records within fourteen (14) days. If said Slides, Blocks, Original Photos are not returned to Palos Community Hospital, I hereby agree to indemnify Palos Community Hospital, its employees, physicians and agents for payment of all claims, demands, settlements, or judgments, costs and expenses on account of or in any way growing out of Palos Community Hospital's inability to defend said claim, demand or lawsuit due to missing blocks, slides or photos. This indemnification shall bind me, my heirs, legal representatives and assigns. I also understand that this will constitute an incomplete medical record, which may compromise my future care and/or treatment and I accept responsibility for any adverse outcome that may result due to the release of said materials

I understand that the original mammography film may be released and transferred permanently to another facility. I understand it is the patient's responsibility for tracking the location of these original films.

Patient Signature

Date

Identification

Legal Representative's Signature/Relationship

Date

Identification

This Section is for Nursing Units for Patients Being Discharged

Send this form to Medical Records, attention R.O.I., after patient completes and signs form.

Medical Records to copy indicated chart forms for release to patient/family member.