



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**

Name of Patient: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT:**

Please print your name: \_\_\_\_\_

Please state your relationship to patient: \_\_\_\_\_

What gives you authority to receive the patient's information?

- \_\_\_\_\_ Written patient authorization (please attach)
- \_\_\_\_\_ You are the patient's parent or guardian (please attach evidence)
- \_\_\_\_\_ You are the patient's health care decision maker (please attach evidence, such as a medical power of attorney)
- \_\_\_\_\_ The patient is deceased and you are the personal representative of the patient's estate (please attach evidence)
- \_\_\_\_\_ Other (please explain): \_\_\_\_\_

**PLEASE RELEASE THE MEDICAL RECORDS FROM:**

\_\_\_\_\_ MacNeal Hospital

\_\_\_\_\_ Other:

\_\_\_\_\_  
**(Physician or Organization)**

\_\_\_\_\_  
**(Street Address)**

\_\_\_\_\_  
**(City, State, Zip Code)**

\_\_\_\_\_  
**(Phone/Fax Number)**

**INFORMATION REQUESTED:** (Check all that apply:)

- |                                |                                    |
|--------------------------------|------------------------------------|
| _____ Medical/Legal Abstract   | _____ Lab Results                  |
| _____ Discharge Summary        | _____ Outpatient Report            |
| _____ History and Physical     | _____ X-ray Report                 |
| _____ Psychiatric Information  | _____ Emergency Room Report        |
| _____ Alcohol/Drug Information | _____ Other (Please specify) _____ |
|                                | _____                              |

The purpose of this release of information: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

This authorization is valid for 90 days. Authorization will expire on: \_\_\_\_\_

I fully understand the following conditions:

1. My medical record and the information therein associated with the dates of treatment and/or hospitalization stated above may contain mental health, development disabilities, alcohol/substance, and/or AIDS/HIV test results.\*
2. The medical record and/or medical information that are to be released herein are privileged and confidential and may be released only by proper authorization, except as required by law.
3. I have the right to a copy of my medical record and to inspect the information and to revoke this authorization at any time by submitting a written revocation to the Medical Record Department.

\*Age 12-17: Patient and parent/legal guardian must sign and date (Psychiatric/Alcohol/Drug).

**CHARGES FOR INFORMATION:**

I understand that I may be charged for the copies as follows:

- ✓ Written medical records will be copied at an allowable charge.
- ✓ Any other types of records can be provided at a charge to be disclosed before copying.
- ✓ All information mailed will be subject to actual postage or other delivery fees.

**METHOD OF DELIVERING INFORMATION:**

\_\_\_\_\_ I will pick up the records at Health Information Management Department

\_\_\_\_\_ I will pick up the records at \_\_\_\_\_ MacNeal Clinic

\_\_\_\_\_ Please mail the records and furnish to:

\_\_\_\_\_  
(Individual or Organization)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Phone/Fax Number)

\_\_\_\_\_ I will review my original record onsite at MacNeal Hospital in the Health Information Management Department. I will call the HIM Department to arrange a time to do so at 708-783-3312.

\_\_\_\_\_ I will review my original record onsite at \_\_\_\_\_ MacNeal Clinic. I will call the to arrange a time to do so at 708-\_\_\_\_\_.

I am authorized to receive copies of the medical and/or billing records for \_\_\_\_\_.  
*(Patient's Name)*

**I understand that I may be charged for the copies of records I have requested and for postage. I agree to pay the total charges when I pick up the copies or, if the copies are to be mailed to me, I agree to pay the charges before the records are mailed.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date