ROSALIND FRANKLIN UNIVERSITY
HealthClinics

AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE (RELEASE) HEALTH INFORMATION
Held or Sought by Rosalind Franklin University Health Clinics

PATIENT INFORMATION

First Name Last Name Maiden/Other name(s) Date of Birth (__/__/__)

Address Phone Number ( )

City State Zip Code

PURPOSE OF INFORMATION RELEASED

☐ Further Treatment/Continued Care ☐ Attorney/Client ☐ Personal Use ☐ Insurance ☐ Other (Specify) _____

MEDICAL RECORDS TO BE RELEASED

Requested Delivery Date:

MEDICAL RECORDS REQUESTED: Dates of Service From:_____ To: _____
(If no dates listed, records will include the past 24 months)

INFORMATION TO BE DISCLOSED:

☐ **Clinic / Office Visit** (Office notes, progress notes, procedure notes, and test results**)**
☐ **Test Results/Reports Only** (check all that apply): ☐ Laboratory ☐ Radiology
☐ **Billing**
☐ **Consultation only**
☐ **Radiology Images** (specify CT, MRI, X-Ray, Ultrasound) _____

Unless otherwise specified, images will be sent on a CD by US Mail

Method of Delivery: ☐ US Mail (Select format): ☐ Paper ☐ Fax ☐ Email to: _____

SEND INFORMATION TO

I authorize Rosalind Franklin University Health Clinics (RFHUC) and its clinical affiliates to release information to:

☐ Please release to myself as the patient or ☐ To another entity (list below)

Name (Example: Health Care Facility, Insurance Co. Attorney)

Address City State Zip Code

( ) - ( ) -

Phone Number Fax Number

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Unless checked or listed below, I understand that the information released may include the following information. Check the associated box if you DO NOT want to include:

☐ AIDS or HIV testing information or test results	☐ Genetic testing and/or genetic counseling records
☐ Substance Abuse/Alcohol treatment	☐ Mental Health/ Developmental Disability

NOTIFICATION TO INDIVIDUAL

In order to protect your privacy, we will not obtain, use, or release your medical records unless authorized by law. I further understand that RFU HC has up to 30 days to review and respond to all medical record requests. Once your written authorization has been received, we may obtain, use, and/or releaser the information indicated within this form. Once the organization or person authorized to receive this information has received it, said information may not be re-released by that organization or person and may no longer be protected by federal privacy laws; however, Illinois law does not allow the re-release of AIDS/HIV, Genetic Testing, Mental Health and Developmental Disabilities, except as allowed by law.

I understand that RFU HC may not condition treatment, payment, enrollment, or eligibility for benefits based upon whether or not this form has been completed. I have the right to withdraw my authorization at any time. Any withdrawal must be in the form of writing and said withdrawal will be valid with exception to release of information which occurred prior to the authorization for withdrawal. If not withdrawn, this authorization will remain valid for a period of six (6) months from the date of signature and will allow for the release of records past the date signed, insofar as the authorization remains in effect. Standard Copying fees per 735 ILCS 5/8-2006 May apply.

By signing below, I agree to the statements within this authorization form.

- **Patients 12-17 years of age** must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing/results, sexually transmitted infections, sexual assault, pregnancy and/or birth control counseling and information.
- **Witness/Signature** is required for mental health and developmental disability information, and genetic counseling to recipient other than patient/self.

Date Time Patient Name/Signature for patients 12 years of age or older

Date Time Signature of (Circle one): *Parent* *Legal Guardian* *Legal representative*

Date Time Witness (Required for Mental Health/Developmental Disabilities records in IL)

PLEASE SUBMIT ALL REQUESTS TO

MAIL: ATTENTION MEDICAL RECORDS
830 W. END COURT, SUITE 400
VERNON HILLS, IL 60067

FAX: (847) 247-6950
DIRECT: (847) 247-6927