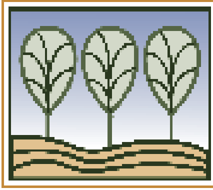

Elmhurst Outpatient Surgery Center
1200 S. York Road | Suite 1400 | Elmhurst, IL 60126
630.758.8800 (p) | 630.758.8805 (f)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Written authorization from the patient or legal representative is required. Please print.

1) Patient's Name: ____ Birth Date: ____________________

2) Patient's Address: ____
(Street, City, State, Zip Code)

3) Dates of Service: ____

4) The protected health information will be (check only one):
   ____ Picked up by patient or their Legal representative
   ____ Faxed (in emergency situations only) to (________) ________-_____________
   ____ Mailed to the address below
   ____ Reviewed by the patient/insurance representative with a Staff Member Present
   ____ Disclosed verbally with the person(s) specified: ____
   ____ Other (please specify):____

   a) Name of Person/Facility/Agency authorized to receive the PHI:

   ____

   Address: ____

   City/State/Zip: ____

   Telephone Number if known: ____

   b) What documents do you need:

   ☐ History and Physical ☐ Discharge Summary
   ☐ Progress Notes ☐ Complete Chart
   ☐ Operative Report ☐ Billing Statements

   ☐Other:____

   c) Reason why this information is to be released (check all that apply):
   ____ Personal copy
   ____ Application for insurance
   ____ Payment of insurance claim
   ____ Continuation of care
   ____ Disability claim
   ____ Legal
   ____ FMLA
   ____ Other: ____

5) I understand that the information to be released may include information relating to the diagnosis and/or treatment of acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental and/or behavioral health, drug and/or alcohol abuse. Please exclude the following information, if possible:

____

6) I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing to the Medical Record Department. I understand that the revocation will not apply to information that has already been released.

7) I understand that I have a right to inspect and/or receive a copy of the medical information to be released and also receive a copy of this authorization form.

8) This authorization will expire on ___________/__________/___________. Otherwise it will expire one year from this date of authorization.

9) I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.

10) I understand that Elmhurst Outpatient Surgery Center will charge a reasonable fee for completing forms and for making copies of the information requested on this authorization.

11) I understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy confidentiality rules.

____ ________________________
Signature of Patient or Legal Representative Date

Relationship to Patient (if other than patient): ____Spouse ____Parent ____Power of Attorney

____ Other (specify): ____

____ ________________________
Signature of Witness (if applicable) or Date
Signature of Staff Member Present During Review

Medical Records Use Only

Patient MRN: ___________________________________

Received by/date: _______________________________ _____ /_____ /______

ID verified _____ ☐ Driver's license _____ ☐ State ID _____☐ Passport

Medical Director authorization: ____

Authorization date: ______/______/______

Payment Amount: $_________________ Method: Cash Check Credit Card Other

Completed by/date: _______________________________ _____/_____/______