LOYOLA MEDICINE

A Member of Trinity Health

Release of Information
Main Email: ROI@luhs.org
Main Fax: 833.675.2688
Main Office: 708.216.5004

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Printed Patient's Name____Phone (______)________-__________

Patient's Birthdate___________________________Email Address____

Address____ City____________________ State_____ Zip_________

DESCRIPTION OF MEDICAL RECORDS REQUESTED

Please select facility from which you are requesting records:

☐ Loyola University Medical Center **| HIM |** 2160 S. First Avenue **|** Mulcahy Center Suite 1605 **|** Maywood, Illinois 60153
☐ Gottlieb Memorial Hospital **| HIM Dept |** 701 W. North Ave. **|** Melrose Park, IL 60160
☐ MacNeal Hospital **| HIM Dept |** 3249 South Oak Park Avenue **|** Berwyn, IL 60402

Other ____

List Date(s) of Treatment ____

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Please select documents to disclose:

☐ Emergency Department Report ☐ Discharge Summary ☐ History and Physical
☐ Consultations ☐ Operative/Procedure Report ☐ Lab/Pathology Results
☐ Progress Notes ☐ Test Results (EKG, EEG, echo) ☐ X-Ray/Diagnostic Results
☐ Summary/Abstract Record Set Specify Test Result____________________

☐ Clinic/Physician Office Notes Specify Provider Name____

☐ Other (list) ____

Please include: ☐ Radiology Images/CD ☐ Itemized Billing Records ☐ Complete Medical Record (Fees may apply)

PURPOSE OR NEED FOR THE DISCLOSURE IS:

☐ Continued Medical Care ☐ Insurance/Payment ☐ Legal Reasons ☐ Patient's Own Use

☐ Other (list) ____

PLEASE DISCLOSE MEDICAL RECORDS TO:

I authorize the medical records indicated above to be provided to the following:

☐ Patient/Myself ☐ Personal Representative ☐ Other, specify below:

Name____

Address ____

Phone__________________________________ Fax__________________________________

FORMAT REQUESTED:(check only one option)
☐ Patient Portal/MyChart ☐ CD ☐ Paper ☐ Inspect a copy
☐ Email If you choose email, insert email address and choose secured or unsecured below Email address _
____

☐ secured/encrypted email ☐ unsecured/unencrypted email *

*If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft. *Please initial if you are requesting unsecured delivery via your personal email listed above. Initials________

**If records are unable to be emailed due to size limitations, please select an alternate format: ☐ Paper or ☐ CD

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Charges for Access: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results**.** If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service to complete most record requests. You may be invoiced directly by the copy service where applicable. You may request to be notified of any charges for approval prior to having your records sent to you.

Information About Your Access Rights: Except under limited circumstances, we will provide you with access to your records. We will respond to your request within 30 days (or 60 days if the extra time is needed to gather records) from the time we receive this completed form. In certain situations, we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to having the denial reviewed.

I hereby request access to my health information as noted above maintained by Loyola Medicine. I understand that the release of my health information MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse, and/or genetic testing.

Please initial below to authorize the release of any of this information

________Alcohol/Drug Abuse or Addiction Diagnosis Treatment

________Behavioral/Mental Health Information (Parent/guardian co-signature required for the release of psychiatric information of patients 12-17 years old)

________Communicable Disease, including Sexually Transmitted Disease

________HIV/AIDS Related Information, including testing and treatment

________Genetic Testing

________Child abuse/neglect, Domestic Abuse by an Adult

________Sexual Assault

If I refuse to sign this Authorization, the Healthcare Provider will not withhold treatment from me and will not release the information to the recipient specified above.

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by the recipient and no longer protected by these regulations.

I understand that I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: ______________________ or upon the following event: _______________________________.
(Date)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)

SIGN HERE____
Signature of Patient or Personal Representative ***Date***

Printed name of patient's Personal Representative, if applicable ____

Describe Relationship to patient (e.g. minor's parent, guardian) ____

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request these records. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc.