LOYOLA MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR WORK-RELATED INJURIES

Patient Name (print): ______________________________________ **Date of Birth:** _____________________________
Address: ____ **City, State, Zip:**_____________________________
Telephone Number: ____ **Social Security Number (Last 4 digits) XXX-XX-**_________

The undersigned hereby authorizes and requests Loyola Medicine (consisting of Loyola University Medical Center, Gottlieb Memorial Hospital, MacNeal Hospital, Loyola Medicine Clinic and other Loyola Medicine entities) as applicable to disclose and furnish *all* records requested to validate the injury:
____
as part of care for injury or condition covered by workers compensation, or records reasonably relating to injury or condition covered by workers compensation, for injury occurring on _______________________(date, an estimate may be provided if exact date not known).

I authorize communication for billing, payment and coordination of care to the verified workers compensation carrier for ___________________(employer). X__________ (initials)

The potential for this information to be redisclosed by this person/facility exists and the information disclosed will *not* be protected by applicable federal/state laws governing the use and release of your health information.

If known, please complete the following detailed information:
Name of person/facility to be released to: ____
Address (City/State/Zip Code): ____
Telephone Number: ____
Fax Number: ____

MY HIGHLY CONFIDENTIAL INFORMATION: By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.

- □ Psychiatric/mental health, mental retardation or developmental disabilities information (Parent/guardian co-signature required for the release of psychiatric information of patients 12-17 years old)
- □ HIV and AIDS testing, diagnosis or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- □ Communicable disease, including sexually transmitted diseases diagnoses/lab results/treatment
- □ COVID-related testing and treatment only □ Alcohol/drug abuse or addiction diagnosis/treatment
- □ Child abuse and neglect □ Domestic abuse by an adult □ Sexual assault □ Genetic testing

You must acknowledge you are checking these categories by signing here:______________

Any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given. You have the right to revoke this authorization except that such revocation will not apply in any uses and disclosures of your information that are described in the above indicated facility Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.

I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the consents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form. To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 S. First Avenue, Maywood, Illinois 60153. Include a copy of this authorization with your correspondence.

Patient/Representative Signature:____Date:_____________________________

State your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for this patient

If the patient is unable to sign, the patient shall mark this release with an "X" and in the presence of two (2) witnesses with their dated signatures below:

Witness Signature:_______________________________ Date_______________________________

Witness Signature:_______________________________ Date_______________________________

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