Elmhurst Outpatient Surgery Center

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Consent Rescinded: Date/Time: Witness:

1. **Patient information**		
Patient's Legal Name:	Date of Birth:	Telephone Number:
Street Address:	City, State, Zip Code:	
Approximate dates of treatment* (*Must be completed)		

2. I authorize the use and disclosure of the individually identifiable health information ("PHI") about me that is indicated in the checklist below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified below.

Specific information to be used or disclosed (check applicable box(es)):

- ☐ Report of Operation
- ☐ Pathology Report
- ☐ Lab Reports
- ☐ Imaging Reports
- ☐ Other: _____
- ☐ Abstract Copy (Tests, Results and Typed Reports)
- ☐ Complete Chart Copy

3. **Authorized to Release (FROM):** I authorize the release of my PHI from Elmhurst Outpatient Surgery Center

4. **Authorized to Receive (TO):** I authorize the Person/Facility/Agency identified below to receive my PHI.

Name and Relationship / Facility and Department:	Telephone Number:
Street Address:	Fax Number:
City, State, Zip Code:	

5. **Purpose(s) of the use or disclosure:**

☐ Continuation of Care ☐ Personal ☐ Insurance ☐ Legal ☐ Disability

6. **Method of disclosure:**

☐ Copyof Record to be set via: ___ Mail ___ Fax

☐ Copy of Record to be picked up

EOSC STAFF ONLY:

Approved: _____

Date Sent: _____ Initials: _____

7. I understand the following:
   - My decision to sign this form and authorize this use and disclosure of health information about me, as described above, is entirely voluntary and I may refuse to sign this form. If this authorization relates to the use or disclosure of mental health information, these are the consequences of my refusal to consent:_____
   - My health care, treatment, payment, or enrollment in a health plan or eligibility for health care benefits may not be conditioned upon my signing this authorization.
   - I may revoke this authorization at any time by giving a written revocation to Elmhurst Outpatient Surgery Center to which I presented this authorization. However, my request for revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law.
   - This authorization expires on (*specify date or event*) _____. If no expiration date is specified this authorization shall be **effective for 1 year** after the date of my signing below, unless revoked by me sooner, or limited or restricted to a shorter time period by applicable law.
   - I am entitled to inspect and copy any information that is used or disclosed based upon this authorization. I am also entitled to a copy of this authorization after signing below; if signing in person at the Facility, I may ask for a copy of this authorization, if one is not provided, before I leave.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

_____ _____

*Signature of Patient or Legally Authorized Representative** (Printed Name) *Date*

_____ _____

If not Patient, Describe Relationship of Legally Authorized Representative to Patient (This section must be completed.) Printed Name

_____ _____

Signature of Witness *(Printed Name)* *Date*

_____ _____

*Signature of 2nd Witness (Printed Name) (ONLY if releasing information to the patient, a guardian, or other legal representative pursuant to a verbal consent.)*** *Date*

***Signature of 2nd Witness:** Written consent should be obtained from each patient before releasing information. If unable to obtain written consent due to incapacitation and/or restraint, verbal consent may be obtained if the information will be provided to the patient, a guardian, or other legal representative. The signature of a second witness is required.*