AdvocateAuroraHealth®

MRN / Chart #: _____

1) **PATIENT INFORMATION:**

_____
Name Address City State Zip

_____ (_____) _____ _____
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

_____
Name of Health Care Provider / Plan / Other

_____
Address

3) **TO DISCLOSE TO:**

☐ Myself *(select delivery option below)*
- ☐ LiveWell/MyAdvocate Aurora portal ☐ View on Site
- ☐ Mail to my address above ☐ Pick up

If Mail or Pick up:
☐ Paper or ☐ Electronic format: _____
☐ If to be picked up by another, I hereby authorize _____ to pick up my records. *(Photo ID required.)*

☐ Send to third party: _____
Attn: _____
Address: _____
_____ *or*
Fax: _____
Third Party Phone #: _____

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

5) **INFORMATION TO BE DISCLOSED:**

☐ Billing Records related to (specify): _____
☐ Emergency Department Reports
☐ Hospital Summary – *a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER.*
☐ Imaging Films (X-ray)
☐ Imaging Results
☐ Immunizations
☐ Lab Reports
☐ Procedure Op Reports
☐ Progress Notes/Updates
☐ Other: _____

I understand that the information to be disclosed may include information regarding genetic testing, mental illness/developmental disabilities, alcohol/drug abuse, HIV Test results, and AIDS/AIDS related illness. We will release this information, unless you indicate which information should be excluded below.

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities ☐ Genetic Testing ☐ AIDS/AIDS related illness

6) **EXPIRATION:** This Authorization is good for: *circle one* 1 month 6 month 1 year

If this item is left blank, the authorization will expire in one year from the date signed.
**IL Only:** If an expiration date is not indicated, mental health/developmental disability records may be released only on the day the authorization is received.

7) **PURPOSE** (Check all that apply - **copy fees may apply)**

☐ Further Medical Care – **no fee** ☐ Insurance Eligibility/Benefits – **fee $**_____ ☐ Legal Investigation /Action – **fee $**_____

☐ Personal (at my request) - **possible fee $** _____ ☐ Forms Completion **- possible fee $** _____ ☐ Other: _____ *(specify)*

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** I understand that I do not need to sign this Authorization to receive treatment. I am aware that I may revoke this Authorization by notifying the health information department in writing. This revocation will not affect information that has been disclosed prior to receipt, or if the disclosure is authorized by law as the authorization was a condition for obtaining insurance coverage. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT/LEGAL REP:** _____ **DATE:** _____

**If signed by a person other than the patient, complete the following:**
1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

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**IL only –** Witness signature for mental health/developmental disabilities records: _____