OSF
SAINT ELIZABETH MEDICAL CENTER

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

If you need assistance in completing this form, please call 815-431-5279.

OSF Saint Elizabeth Health Information Services is keeper of medical records for these type of visits:

Inpatient/Observation (overnight)
Emergency Department
Hospital ambulatory/outpatient surgery
Same day testing i.e. Laboratory, Radiology and Cardiology
Pain Clinic
OSF Center for Health - Streator (after 1/4/16)

Who should I contact if I need records or information from other departments?

Radiology Imaging CD	Call Radiology at 815-431-5207.
OSF Medical Group	Call your individual physician's office.
Prompt Care	Call (815) 434-2273 for the Norris Drive location. Call (815) 431-9208 for the First Avenue (Route 23) location.
Itemized Statements/Bills	Call OSF PAAC at 309-683-6750 or toll free at 800-421-5700.
Laboratory slides	Call Laboratory at 815-431-5251 or 815-431-5211.

1. **Read entire document. Complete steps 1-7. Sign, date and have witness sign on page 2. Return completed form by fax (815-431-5503), e-mail attachment to SEMC.ROI@osfhealthcare.org or by mail to address in step 2.**

Patient Name:	DOB:	Last 4 of SSN:
Address:	City:	State/Zip
Email Address:	Phone:	Alt. Phone:

2. Who is sending your information? The following organization or individual **is authorized to release the information** or **make the disclosure**.

	OSF Saint Elizabeth Medical Center	Phone:	815-431-5279
MAILING	Health Information Services (Medical Records)	Fax:	815-431-5503
ADDRESS	1100 E. Norris Drive	E-mail Address:	SEMC.ROI@osfhealthcare.org
	Ottawa, IL 61350		

3. Specify **visit dates** or range of dates needed: _____

_____

_____

4. What information would you like to release? The **nature of the information** to be used or disclosed.

☐ Abstract includes H&P, Consult, OR, Pathology, DS, ER and Test Results i.e. Laboratory, Radiology, Cardiology.			
☐ History & Physical	☐ Emergency Report	☐ Progress Notes	☐ Specify other report
☐ Discharge Summary	☐ Operative Report	☐ Rehab Records	
☐ Test Results	☐ Pathology Report	☐ Entire Record with flow sheets (i.e. temps, blood pressure)	

a. My medical record may include **sensitive information** such as mental/behavioral health, developmental disability, sexually transmitted diseases and/or alcohol/drug abuse and **will be released.** I may **choose NOT to release** sensitive information by checking here. ☐

b. I hereby expressly authorize the release of: Genetic testing ☐ HIV/AIDS ☐

5. Deliver my information to the name and address below. This information **may be disclosed to or used by** the following individual, class of persons or organization.

Name:	Address:		City/State/Zip:
E-mail Address:	Phone:		Alt. Phone:

6. **The disclosure is made for the purpose(s) of**: _____.

7. How do you want information **delivered**? Select one of the following options.
Visit dates from 6/15/2013 to present can be delivered by OSF MyChart *or E-mail. Prior visits may be delivered by US mail.*

☐	OSF MyChart	*If you currently have* OSF MyChart, *or to sign up, visit* www.osfmychart.org, *then call 815-431-5279 to request record to download or on mobile app, searchable by* MyChart *via Google Play or Apple Store.*	*Estimated turnaround time same day to 3 business days.*
☐	E-mail, private (encrypted)	*If you prefer records be sent by unencrypted mail and understand and accept that there may be associated risks, check here.* ☐	*Estimated turnaround time 3 to 5 business days.*
☐	USPS Mail	*US Postal Service handling of incoming and outgoing mail may affect actual turnaround time.*	*Estimated turnaround time 3 to 10 business days.*

Note: Faxing is not an option to deliver medical records. *For office use only:* _____

8. I understand any disclosure of information carries with it the **potential for an unauthorized re-disclosure** and the information **may not be protected** by federal privacy laws. Sensitive information **will continue to be protected** by Illinois Law and may be subject to re-disclosure by recipient ONLY if I specifically provide permission for the re-disclosure. If I have questions about privacy of my health information, I can contact OSF Saint Elizabeth Health Information Services at (815) 431-5279.

9. I understand I have the **right to inspect or copy** the information to be used or disclosed.

10. I understand I have **the right to revoke** this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

11. This authorization **will expire 1 year from the date of signature** on this authorization form or **upon a date, event or condition** that I am specifying here :

12. I understand that authorizing the disclosure of this health information is **voluntary**. I can refuse to sign this authorization, which will **prevent disclosure of information**. I understand that the above persons or organization authorized to make the requested disclosure **may not condition treatment or payment** upon completion of this form.

_____ _____
Signature of Patient (18 or over) / Signature of child (12-17) for MHDD purposes only Date
405 ILCS 5 Mental Health and Developmental Disabilities (MHDD)

_____
Signed by Patient Representative (parent, guardian, HC-POA), *state relationship to Patient and provide evidence of Authority under applicable law to act for patient. If current evidence of Authority to act for patient is already on file at OSF, check here* ☐.

a. Health Care Power of Attorney (HC-POA)
   1. If patient is currently making decisions for themselves, then patient signs this form.
   2. If patient has chosen to allow HC-POA to make decisions for them or physician has determined patient lacks ability to make decisions for themselves, then HC-POA signs this form and attaches evidence of Authority to act for the patient.

b. Deceased patient records: Please call 815-431-5279 for more information.

_____
Signature of witness who can verify Patient Identity or Patient Representative