

MIDWEST HEART SPECIALISTS

AUTHORIZATION

(Illinois Provider)

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes state.

FEES FOR MEDICAL RECORDS:

- **No Charge for 2 year history**
- **\$25.00 per 5-year period for complete history**
 - **Fee is due at time of request**
- **Beyond 5 year history additional charges will apply based on number of pages**
 - **Fee is due at time of request**

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

MHS Account #: _____ Date of Birth ___/___/___ Last 4 digits of SSN _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your treatment on receiving this authorization. If you are temporarily prohibited from completing and signing this authorization for religious reasons, you will not have to do so at this time, but will complete it as soon as you are able to.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant this authorization may not be further disclosed except pursuant to my authorization. You have the right to inspect and copy any mental health records disclosed pursuant to this authorization. If you are authorizing the disclosure of psychological tests, such tests may only be disclosed to a psychologist that you have designated.

SECTION: B: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/Or Disclosed: Release of information *will* include sensitive information information, such as mental, substance abuse, genetic or HIV/AIDS **unless checked below.**

Check and initial if applicable:

Mental Health Initial _____ HIV/AIDS Initial _____ Genetic Testing Initial _____

Other (please specify) _____
 _____ Initial _____

Purpose of this Authorization

- At the request of individual (or the individual's personal representative).
- For the following purposes:

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

SECTION C: Expiration and revocation:

Expiration: This authorization will expire (complete one:

- 14 days from date of signature or 14 days from receipt of check if applicable
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Office: Midwest Heart Specialists – Attn: Privacy Officer
Telephone: 630-991-2067
Address: 1919 S. Highland Ave, Suite B202, Lombard, IL 60148

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.