

MIDWEST HEART SPECIALISTS

Release of Records Authorization

Midwest Heart Specialists office that records to be released from:

- Barrington Office: 27750 W Route 22, Suite 240 Barrington, IL 60010 Phone: (847) 829-1600
- Downers Grove Office: 3825 Highland Ave, Tower 2 Suite 400, Downers Grove, IL 60515 Phone: (630) 719-4799
- Elmhurst Office: 133 E. Brush Hill Rd, Suite 202, Elmhurst IL 60126 Phone (630) 782-4050
- Hoffman Estates Office: 1555 N. Barrington Rd, Bldg 3 Suite 3200 Hoffman Estates, IL 60196 Phone(847) 882-8448
- Naperville Office: 801 S. Washington, 4th Floor Heart Hospital, PO Box 3226, Naperville IL 60566 Phone (630) 527-2730
- Winfield Office: 25 N Winfield Rd, Suite 301, Winfield, IL 60190 Phone (630) 510-9244

FEES FOR MEDICAL RECORDS:

- NO CHARGE 2 years of records or less
- \$25.00 charge 2-5 years of records
- \$35.00 charge 5 years of records and beyond

*****Fee is due at time of request. Please make check payable to- "Copy Source"**

- I will pick up records
- Please mail records to: Home address Other _____

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:

You may revoke this authorization at any time by giving written notice of revocation to the Midwest Heart Specialists Office listed at the top of this form as the releasing office. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

In the event that written revocation of this consent is not made, this authorization will automatically expire when one of the two conditions listed below are met:

- 14 days from date of signature or 14 days from receipt of check if applicable
- On occurrence of the requested information being released

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.