ST. BERNARD HOSPITAL
AND HEALTH CARE CENTER
326 WEST 64TH ST, CHICAGO, IL 60621
PHONE 773.962.4089 FAX 773.962.4219

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby authorize the use or disclosure of my health information by St. Bernard Hospital as described below. I understand that this authorization is voluntary. I further understand that if the organization authorized to receive this information is not a health care provider or health plan, the released information may no longer be protected by federal and state privacy regulation.

THIS REQUEST IS FOR MEDICAL RECORDS ONLY

Patient Name:_____ Date of Birth: _____

Address:_____ Phone: (_____) _____

SS#: _____

PERSON OR ORGANIZATION RECEIVING/SENDING THE INFORMATION

From/To:_____

Address:_____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for 90 days from the date of signature. This consent is also subject to revocation by the undersigned at any time between now and the release of information by notifying St. Bernard Hospital in writing. I understand that actions taken before the receipt of the written revocation will not be affected.

Preferred Output? (*CD is default*)
☐ **CD** ☐ **Paper**

IMPORTANT – PLEASE READ: Copy Fee for Patient Records ($1.02 per page for pages 1–25; $.68 per page for pages 26–50; $.34 per page for pages in excess of 50). Copies from microfiche or microfilm = $1.71 per page. The charge is reduced by 50% per page when the record is released on CD. The processing time frame for medical records request is 10–15 business days.

DISCLOSURE IS LIMITED TO MEDICAL INFORMATION REGARDING ADMISSION, MEDICAL DIAGNOSIS, OR TREATMENT (check all that apply):

☐ **Medical Information (specify)** _____

☐ **X–ray Films**	☐ **Mammogram**	☐ **CT Scan**
☐ **Nuclear Medicine**	☐ **Ultrasound**	☐ **EEG Report**
☐ **Pathology Slides**	☐ **Pathology Report**	☐ **Sexually Transmitted Disease Related Information**

☐ **Other** _____

The requester may use the medical records and type of information authorized only for the following purposes: _____

_____

_____

I assume full responsibility for radiology film and/or pathology slides and understand that they must be returned upon completion of review.

☐ Please provide an abstract of my medical record for period From:_____ To: _____
* Note you will be invoiced at the allowable IL Statute rate

☐ Please provide my entire medical record for period From:_____ To: _____
* Note you will be invoiced at the allowable IL Statute rate

* For current Illinois Statute Copy Fee please see Illinois State Comptroller web site at www.ioc.state.il.us/office/fees.cfm

Authorization to Release Protected Information

Required – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical record.

I ☐ DO	☐ DO NOT want information about ***Mental Health** released	_____
I ☐ DO	☐ DO NOT want information about ***HIV Tests & Related Information** released	_____
I ☐ DO	☐ DO NOT want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ DO NOT want information about _____ released	_____

Other sensitive information?

Initial each line to confirm choices

STOP! Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless if they are applicable or not. If form is incomplete, no protected information will be released.

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING: (check one)

☐ Patient named above is a minor _____years of age

☐ Patient named above is unable to sign because: _____

For this reason I am signing on behalf of the patient named. Indicate relationship to patient: _____

Signature: _____ Date\Time: _____

Witness: _____ Date\Time: _____

REDISCLOSURE NOTICE

This information has been disclosed to you from records whose confidentiality is protected by Federal regulations (42 C.F.R Part 2 and 45 CFR) and HIPAA Public Law 104–191 which prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Request a Copy of Your Medical Records

We are happy to provide copies of your medical records upon request.

To Obtain Copies of Your Medical Records

1. An authorization to release your medical records, radiology film and/or pathology blocks and slides must be completed, signed and dated by the patient or the patients personal representative before records can be provided.

2. Your request will take 10 to 15 business days to be processed upon receipt of a valid authorization. Please allow additional days for mailing.

If you are going to mail in your authorization please send it to:

St. Bernard Hospital and Health Care Center
Attention: Release of Information
326 W. 64th St.
Chicago, Illinois 60621

If you fax your request, fax it to (773) 962–4219. Please call to confirm that it was received.

If you have any questions regarding your request, please call Release of Information at
(773) 962–4089

Medical Record Pick–up Hours
Monday–Friday
8:30a.m – 4:00p.m
Go to the information desk and they will direct you to Release of Information.

PLEASE NOTE: THE DEPARTMENT IS CLOSED ON WEEKENDS AND HOLIDAYS