INSIGHT
HOSPITAL & MEDICAL CENTER

2525 s Michigan Ave.
Chicago IL 60616
Phone: 312-567-2104 Fax: 312-567-2068
www.insightchicago.com

Authorization for Release of Health Information

SECTION 1: Patient Information (Please print and complete ALL blanks)

First Name: ____________________ Last Name: ____________________ Date of Birth: _________________
Address: __________________________ City/State/Zip: ____________________ Phone: __________________

Person Requesting Medical Records:

☐ Patient (Self) ☐ Power of Attorney (POA) ☐ Parent (of patient under 18 years of age) ☐ Legal Representative

If not patient (self), the authorized representative to whom the record will be released is as follows:

First Name: ____________________ Last Name: ____________________ Date of Birth: _________________
Address: __________________________ City/State/Zip: ____________________ Phone: __________________

At least one of these two must be checked and obtained:

☐ Copy of patient's ID obtained ☐ Copy of representative's ID obtained

SECTION 2: Information Request (Please Check all appropriate boxes)

The SPECIFIC type of information to be used or disclosed ("All Records" or incomplete dates are NOT considered specific):

☐ SPECIFY Hospital or Clinic/Physician:____

☐ Radiology Reports ☐ Radiology Images ☐ Discharge Summary ☐ Labs ☐ Operative Reports ☐ Immunizations
☐ Consultation Notes ☐ Progres Notes ☐ ER Reports ☐ History and Physical ☐ Cardiac Testing
☐ Other:____

Include the following SENSITIVE records: { } Mental Health { } HIV/AIDS/STD { } Genetic Testing

☐ Drug/Alcohol Abuse: Witness Signature required in Section 6 for release of these sensitivie record types; for a minor aged 12-17 the minor's signature is required in Section 6 for the release of the Mental Health, HIV/AIDS/STD or Drug/Alcohol Abuse Records For the following dates of treatment ___________________________________ (Specific Date 1/2/2022 OR Range of Dates: January-July of 2022)

SECTION 3: I authorize Insight Hospital and Medical Center to release the above patient records to:

Name of Individual/Organization: ___________________________________ Phone: ______________________

Address: ______________________________ City/State/Zip: _____________________ Fax: _________________

SECTION 4: Method of Delivery (e-Delivery excludes radiology images)

☐ Fax ☐ US Mail ☐ Secure e-Delivery (Requires Internet Access - secure e-fax, portal delivery)
☐ Call for Pickup by patient or their legal representative (2525 S. Michigan Ave. Chicago, IL.). A photo ID is required for pick-up.

SECTION 5: Purpose for Disclosure (records are subject to change)

{ } Continuation of Care { } Personal Reasons { } Insurance { } Legal { } Other: _________________________________

SECTION 6: Signatures

*I understand I have the right to revoke this authorization inwriting at any time sending revocation to Insight's ROJ Department at 2525 S. Michigan Ave, Chicago, IL 60616. The revocation will not apply if Insight has already taken action in reliance on the authorization.

*I understand this authorization will expire in 90 days or upon the following specific date:___________________or even ________________________

*I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.

*I understand I have the right to refuse to sign this authorization and Insight does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. preemployment or life insurance physicals).

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature ____ **Date:** __________________________________

Representative Signature (For Minor, POA, etc.) _______________________ **Relationship:** _____________ **Date** ___________

Witness Signature ________________________ **Date** ____________________
(Witness Signature required for any sensitive records to be released if so selected in Section 2)

Form & ID to be scanned into patient's electronic medical record after the processing of requested record is complete.