LOYOLA
UNIVERSITY
HEALTH SYSTEM

Loyola University Chicago

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (Print): _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Social Security Number: _____ Telephone Number: ( ) _____

The Undersigned hereby authorizes and requests the Director of Medical Records and/or her designee (e.g. MMRA Copy Service) of ***Loyola University Health System*** ("LUHS") to disclose and furnish this requested information to the person/facility below. The potential for this information to be re-disclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to: ExamOne

Address (City/State/Zip Code): 800 NW Chipman Rd. / Suite 5900

Phone Number: ( )_ Toll Free 888-521-2004 (FAX: 800-997-2771) POBox 2340 Lee's Summit, MO 64063-1149

Dates of your *treatment/service* that you want released: _____

Purpose for which you want this information released: _____

INFORMATION TO BE RELEASED (check all that Apply)

- ❑ Lab Results
- ❑ Outpatient Records
- ❑ Emergency Room Record
- ❑ Cardiac Cath Report
- ❑ Immunization Record
- ❑ Pathology Written Report
- ❑ X-ray/radiology Written Report
- ❑ Operative Report
- ❑ Abstract (Includes: Discharge Summary, Operative Reports, History & Physical, X-ray/radiology Written Report, Pathology, Consults if applicable.)
- ❑ Pathology slides/blocks (pick-up in the Pathology Department)
- ❑ Other (Specify): _____

SECTION A: If your health information contains *any of the following*, please check all the categories that apply so that this request is not delayed. *You must also acknowledge that you are checking these categories by furnishing your written signature here*: _____.

- ❑ Psychiatric/mental health or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17-years old).
- ❑ AIDS/related illness, diagnosis or treatment HIV test results Genetic testing
- ❑ Alcohol/drug abuse diagnosis or treatment

SECTION B: This authorization is valid until ____/____/____ (You must specify the month, date and year or we cannot process this request). You have the right to revoke this authorization except that such revocation will not apply to any uses and disclosures of your information that are described in the LUHS Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted. To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 So. First Avenue, Maywood, IL., 60153. Include a copy of this authorization with your correspondence.

Patient/representative signature: _____ Date: _____

What is your relationship to the patient, if the patient is unable to sign, or the authority you have to act on behalf of this patient? You must be able to furnish proof of relationship or authority to act for the patient: _____.

(Over Please)

If the patient is unable to sign, the patient shall mark this release with an "x" and in the presence of two (2) witnesses with their dated signatures below:

NOTE: LUHS CANNOT CONDITION TREATMENT BASED ON YOUR SIGNING OF THIS AUTHORIZATION

Witness signature: _____ Date: _____

Witness signature: _____ Date: _____

SECTION C: ATTORNEY'S ONLY

If you are an **attorney** making this request pursuant to legal subpoena, discovery request or "other lawful process", in the absence of patient authorization or a court order, you must provide satisfactory assurance that the patient was provided with sufficient notice and opportunity to object to this release of protected information.

(CHECK ALL THAT APPLY)

EITHER

- ☐ You have made a good faith effort (such as by sending a notice to the individual's last known address) to provide written notice to the individual who is the subject of this request, AND
- ☐ The notice identifies the litigation at issue with sufficient specificity to allow the individual to raise an objection, AND
- ☐ The time to raise an objection has passed and no objections were filed, or if filed, were resolved to allow disclosure.

OR

- ☐ In lieu of notice, reasonable efforts were made to secure a "qualified protective order", AND
- ☐ The parties have agreed to the qualified protective order and have presented it to the court or administrative tribunal, OR
- ☐ The party seeding the information has requested a qualified protective order from the court or administrative tribunal.

Attach any written documentation to support the above representatives to this form.

ATTESTATION OF ATTORNEY

I hereby acknowledge that the patient/subject, or patient/subject's legal representative (parent or guardian), was provided with sufficient notice and opportunity to object to this release of protected health information and that an objection or response has not been received. I also represent that the protected health information requested meets the "minimum necessary standard" as described in the HIPAA Privacy Rule.

Attorney Signature: _____ Date: _____

Law Office Address: _____

City/State/Zip Code: _____ Telephone Number: _____