ROCKFORD HEALTH system

IT'S CALLED COMMITMENT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME_____ MAIDEN NAME _____ BIRTHDATE _____MR#_____
Last Name, First Name, Middle Initial

ADDRESS_____ CITY_____ STATE____ ZIP_____ PHONE #_____

I, authorize:
- ❑ Rockford Clinic, 2300 N. Rockton, Rockford, IL 61103
- ❑ Rockford Memorial Hospital, 2400 N. Rockton, Rockford, IL 61103
- ❑ Visiting Nurses Association, 4223 E. State, Rockford, IL 61108

(X) To Release to: ExamOne
( ) To Receive from: 800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

SPECIFIC INFORMATION TO BE RELEASED:

HOSPITAL RECORDS	**CLINIC RECORDS**	**VNA RECORDS**
_____Inpatient Date(s): _____	Office notes of : Date(s)	_____
_____Outpatient Date(s): _____	( )Dr./Dept._____ _____	Date
_____Emergency Room Date(s): _____	( )Dr./Dept._____ _____	
	( )Dr./Dept._____ _____	
_____Abstract Only *(Discharge Summary, History & Physical, Operative Reports, Pathology Reports, Consults, EKGs, Radiology Reports, Laboratory Reports)*	( )Lab _____	
	( )X-ray Reports _____	
	( )EKG _____	
_____Other_____	( )Immunization Record _____	
	( )Other_____	

- **The purpose of this disclosure of information is** _____
(i.e. continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record **may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, developmental disabilities, or treatment for alcohol and/or drug abuse.**
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I may contact the Director of Health Information Services for questions regarding disclosure of my health information.
- I understand that my refusal to consent to the release of the above mentioned information will prevent the disclosure of the information. I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency. If I refuse to authorize release of information for this purpose, it may adversely affect my entitlement to insurance benefits.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in six months.

_____ DATE: _____
Signature of Patient or Legal Representative

_____
If signed by other than the patient, state relationship

_____ DATE: _____
Witness

-Illinois Mental Health & Developmental Disabilities Confidentiality Act - Chapter 91.5, Section 803 - Minors ages 12 - 17 years old: Patient, parent (legal guardian), and witness must sign and date.
-Minors 12 - 17 years old may authorize the release of alcohol and/or drug abuse information. (Federal Regulation 42CFR)

MR26.91

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