GOTTLIEB MEMORIAL HOSPITAL
701 W. NORTH AVENUE
MELROSE PARK, IL 60160
(708) 681-3200

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Patient Name Medical Record Number/Radiology Number

_____ _____ _____
Birth Date Social Security # Telephone Number

I hereby authorize _____, its Director or designee, to release information contained in the medical records of the patient identified above including any mental health, development disability, drug and alcohol abuse records in accordance with Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. **I specifically authorize the release of information regarding:**

_____ Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or Acquired Immunodeficiency Related Complex (ARC).

The information may be released to the following:

1. NAME AND ADDRESS TO WHOM THE INFORMATION IS TO BE DISCLOSED:

_____
_____

2. SPECIFIC INFORMATION TO BE DISCLOSED: _____

Date(s) of Service

_____ Abstract _____ Films/CD _____ Entire Medical Record
_____ All Mammogram Films/Reports _____ Other: _____

3. PURPOSE AND NEED FOR SUCH DISCLOSURE: _____

4. This consent is subject to revocation at any time except in those cases in which the Hospital has acted with the understanding that the consent will continue in effect until the stated purpose has been accomplished. However, any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given.

5. Without expressed revocation, this consent expires 90 days subsequent to signing, on the date set forth below, or for the following specified reasons:
Date: _____, or Event/Condition: _____

_____ _____
Signature of patient/legal representative **Signature of witness**

_____ _____
Date Signed **Date witnessed**

Relationship to patient if not signed by patient _____

Indicate why patient is unable to sign:
_____ Minor _____ Ward _____ Deceased _____ Other, explain: _____

NOTE TO AUTHORIZING PARTY: There is the potential that the protected health information that we release subsequent to this authorization may be re-disclosed by the recipient and thus, would no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (Privacy Rule).

NOTE TO RECEIVING AGENCY/PARTY: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Rev9/07