LaSalle County
Human Resources Department
707 E. Etna Road
Ottawa, IL 61350
Phone: 815-434-8244

HIPAA MEDICAL RECORD DISCLOSURE AUTHORIZATION

Patient Name: _____ SSN: _____
Address: _____ Date of Birth: _____
_____
Phone Number: _____

The undersigned herby authorizes and requests any Medical Records Department, Billing Department, Physician, Surgeon, Hospital, Nursing Home, Clinic, Ambulance Owner, Nurse, Insurance Company, Employer, or any other person or organization and/or their designee (e.g., a record copy service) to disclose and furnish the information requested below to:

CCMSI
3333 Warrenville Road, Suite 550
Lisle, IL 60532

Purpose of Disclosure: This authorization is made for the purpose of copying records in connection with a lawsuit or claim to which the patient is or may be a party.

Re-disclosure: The potential for this information to be re-disclosed by the recipient exists and will not be protected by applicable federal and state laws governing the use and release of this health information.

Revocation: This authorization may be revoked at any time by the undersigned in writing. A revocation will, however, not apply to information that has already been released in response to this authorization.

Expiration Date: This authorization shall be in force until the conclusion of the pending litigation or claim.

Description of Information Requested: Any and all medical records and information relating to the care and treatment of the patient, including x-rays, photographs, electronic and digital files, and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or AIDS related complex.

Copy: A copy of this authorization shall be as valid as the original.

Description of Personal Representative's Authority (if applicable)

_____

_____ _____
Signature of Patient or Representative Date