

**KISHWAUKEE HEALTH SYSTEM - AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize Kishwaukee Health System to release:  
 I authorize \_\_\_\_\_ to release:

Check all that apply

- Face Sheet \_\_\_\_\_
- Emergency Dept. Report \_\_\_\_\_
- History/Physical \_\_\_\_\_
- Operative Report \_\_\_\_\_
- Discharge Summary \_\_\_\_\_
- Consultations \_\_\_\_\_
- Lab Results \_\_\_\_\_
- Blood Alcohol Results \_\_\_\_\_
- X-ray Reports/Films \_\_\_\_\_
- ECG \_\_\_\_\_
- Transfer Forms \_\_\_\_\_
- Mental Health Records\*\* \_\_\_\_\_
- Substance Abuse Records \_\_\_\_\_
- HIV/Aids Records\*\* \_\_\_\_\_
- Sexual Assault/Abuse \*\* \_\_\_\_\_
- Office/Home Visit Report \_\_\_\_\_
- View Record \_\_\_\_\_
- Other \_\_\_\_\_

From the Medical Records(s) of:  
 \_\_\_\_\_  
 (patient name)  
 \_\_\_\_\_  
 (birth date)  
 \_\_\_\_\_  
 (social security number)  
 \_\_\_\_\_  
 (applicable dates, if known)

To: personal physician/receiving agency/ other: \_\_\_\_\_

\_\_\_\_\_ (address)

For the purpose of  Medical    Personal    Billing    Other - \_\_\_\_\_

This Authorization will expire \_\_\_\_\_, 90 days from date signed.  
 (month/day/year)

- ◇ I understand that there will be a copying fee based upon the number of pages requested.
- ◇ I understand that my refusal to consent to the release of the above mentioned information may prevent the disclosure of the information.
- ◇ I understand that I have the right to request, inspect and copy the above mentioned information and that my request may be denied.
- ◇ I understand that I have the right to revoke this authorization by giving written notice to the Privacy Officer, 626 Bethany Road, DeKalb, IL 60115.
- ◇ I understand in certain circumstances any request may be denied. If my request is denied I will be notified of this denial.

\_\_\_\_\_  
 Signature of patient or legal representative\*

\_\_\_\_\_  
 Signature of witness

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date

**\*If not signed by the patient, indicate legal relationship to patient and legal basis on which consent is given.**  
**\*\*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

**PATIENT LABEL**  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Date of Service: \_\_\_\_\_