VANGUARD | MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name of Patient: _____ **Medical Record Number:** _____

Date of Birth: _____ **Telephone Number:** _____

IF YOU ARE NOT THE PATIENT:
Please print your name: _____

Please state your relationship to patient: _____

What gives you authority to receive the patient's information?
_____ Written patient authorization (please attach)
_____ You are the patient's parent or guardian (please attach evidence)
_____ You are the patient's health care decision maker (please attach evidence, such as a medical power of attorney)
_____ The patient is deceased and you are the personal representative of the patient's estate (please attach evidence)
_____ Other (please explain):
_____

PLEASE RELEASE THE MEDICAL RECORDS FROM:
_____ Vanguard MacNeal Hospital
_____ Other:

_____
(Physician or Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone/Fax Number)

INFORMATION REQUESTED: (Check all that apply:)

_____ Medical/Legal Abstract	_____ Lab Results
_____ Discharge Summary	_____ Outpatient Report
_____ History and Physical	_____ X-ray Report
_____ Psychiatric Information	_____ Emergency Room Report
_____ Alcohol/Drug Information	_____ Other (Please specify) _____

The purpose of this release of information: _____

_____

Dates of treatment: _____

This authorization is valid for 90 days. Authorization will expire on: _____

I fully understand the following conditions:

1. **My medical record and the information therein associated with the dates of treatment and/or hospitalization stated above may contain mental health, development disabilities, alcohol/substance, and/or AIDS/HIV test results.***
2. **The medical record and/or medical information that are to be released herein are privileged and confidential and may be released only by proper authorization, except as required by law.**
3. **I have the right to a copy of my medical record and to inspect the information and to revoke this authorization at any time by submitting a written revocation to the Medical Record Department.**

***Age 12-17: Patient and parent/legal guardian must sign and date (Psychiatric/Alcohol/Drug).**

CHARGES FOR INFORMATION:
I understand that I may be charged for the copies as follows:

- ✓ Written medical records will be copied at an allowable charge.
- ✓ Any other types of records can be provided at a charge to be disclosed before copying.
- ✓ All information mailed will be subject to actual postage or other delivery fees.

METHOD OF DELIVERING INFORMATION:

_____ I will pick up the records at Health Information Management Department

_____ I will pick up the records at _____ Vanguard Medical Group Clinic.

_____ Please mail the records and furnish to:

_____
(Individual or Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone/Fax Number)

_____ I will review my original record onsite at Vanguard MacNeal Hospital in the Health Information Management Department. I will call the HIM Department to arrange a time to do so at 708-783-3312.

_____ I will review my original record onsite at _____ Vanguard Medical Group Clinic.
I will call to arrange a time to do so at 708-_____.

I am authorized to receive copies of the medical and/or billing records for _____.
(Patient's Name)

I understand that I may be charged for the copies of records I have requested and for postage. I agree to pay the total charges when I pick up the copies or, if the copies are to be mailed to me, I agree to pay the charges before the records are mailed.

_____ _____
Signature **Date**

_____ _____
Parent/Legal Guardian Signature **Date**