



(For Official Use Only)

**RUSH**  
**AUTHORIZATION FOR RELEASE OF**  
**PATIENT HEALTH INFORMATION**

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MEDICAL RECORD # \_\_\_\_\_

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:**

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action Rush took in reliance on this authorization before Rush received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that if the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. I understand that I have a right to inspect and copy the information to be disclosed pursuant to this authorization and that I may obtain a copy of the information by contacting the office listed above.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Rush. I understand that, by signing this form, I am confirming my authorization that Rush may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

**EFFECTIVE: This authorization request does not apply to any treatment dates beyond the date of signature. You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire, unless mental health records are requested. Otherwise, this authorization will expire ninety (90) calendar days after the date of signature.**

**PATIENT/PERSONAL REPRESENTATIVE'S SIGNATURE:**

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
If signed by other than patient: PRINT representative name

Phone # \_\_\_\_\_

\_\_\_\_\_  
If signed by other than patient: State relationship to patient

\*(Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if over the age of 12 and under the age of 18.)

\_\_\_\_\_  
Witness signature

Date: \_\_\_\_\_

\_\_\_\_\_  
PRINT Witness name

Phone # \_\_\_\_\_

\_\_\_\_\_  
State relationship to patient