PLAINFIELD SURGERY CENTER, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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| --- | --- |
| **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**I hereby request Plainfield Surgery Center, LLC to allow me to obtain a copy of the following records:**

Operative report  Specific surgical visit-date \_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
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| **Address1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Home Phone: \_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **City/State/Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Purpose of Disclosure:**

**Personal Reason**  Insurance  Legal  Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of Delivery: Photo ID is required**

Fax  U.S. Mail   Pick up at 24600 W 127th St Building C Plainfield, IL 60585

**I further understand that:**

1. All healthcare providers, including Plainfield Surgery Center, LLC maintain certain protected health information about me as a patient, such as medical and billing records, and records that are used, in whole or in part, to make decisions about me, my treatment, or billing for services rendered.
2. I have the right to inspect and obtain a copy of my above-mentioned protected health information maintained by Plainfield Surgery Center, LLC.
3. My request must be made in writing using this form, which must be completed prior to Plainfield Surgery Center, LLC providing me with the requested information.
4. If I request Plainfield Surgery Center, LLC to copy and mail the requested information, they have the right to charge me for copying and mailing the requested information to me.
5. I have the right to request an amendment to my protected health information mentioned above.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Patient or Legal Representative** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Printed Name of Patient’s Representative (*if applicable*)** | **Relationship to Patient (*if applicable*)**  Parent or guardian of unemancipated minor  Court appointed guardian.  Executor or administrator of decedent's estate  Power of Attorney |

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**Request**  Accepted  Denied FOR OFFICE USE ONLY

**Reason for Denial** (*if applicable*)

Access is likely to endanger the life or physical safety of the individual or another person.

Psychotherapy notes

The information is compiled for use in a civil, criminal, or administrative action or proceeding.

Other (*full list of other reasons for possible denial at 45 CFR §164.524(a)(1)-(3)*):

**Date Request Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Request Fulfilled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fulfilled By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Extension Requested \_\_\_\_Yes \_\_\_\_No Date Patient Notified in Writing of Extension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Extension Requested, Give Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2/15/2021**