OSF HEALTHCARE
Cardiovascular Institute

Request for Release of Confidential information

I,_____(patient name) SS#_____

Date of birth_____authorize the release of confidential information from my medical record

From: _____
_____
_____

To:

__ **Peoria Office, 5405 N. Knoxville,**
Peoria, Illinois 61614 (309)691-4410 Fax (309)692-4730

__ **Pekin Office, 610 Park Avenue,**
Pekin, Illinois 61554 (309)346-7776 Fax (309)353-6514

__ **Galesburg Office, 834 N. Seminary St., Suite 201B**
Galesburg, Illinois 61401; (309)343-7775; Fax (309)343-2726

For Dr.:_____

This confidential information is being disclosed for the purpose of _____
(example: continuation of care)

Include information specified below, including diagnosis and records of any treatment or examination rendered to me from __/__/__ to __/__/__.

-I have the right to revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage) by submitting a written revocation request to the Medical Record Department at HeartCare Midwest. If not revoked, this authorization will expire 90 days from the date signed below.
-My refusal to consent to the release of the above-mentioned information will prevent the disclosure of the information.
-There is potential for the authorized information to be subject to redisclosure by the recipient and is therefore no longer protected under the Privacy Rule.

__Abstract of record (pertinent information only)
__History and Physical
__Consultation (s)
__Discharge Summary
__EKG tracings
__Holter monitor report
__Holter monitor tracings
__Exercise treadmill report
__Exercise treadmill tracings
__Nuclear & treadmill report
__Copies of nuclear images

__Radiology Reports
__Cardiac catheterization, angiography report
__Cardiac catheterization films or disc
__Emergency room sheets/reports/testing
__Laboratory reports
__Echocardiogram report
__Echo tapes
__Stress echo report
__Stress echo tracings
__Stress echo tape or disc
__Other_____

Include psychiatric and/or chemical dependency information?
___Yes ___No

Include developmental disability information?
___Yes ___No

Include the disclosure of blood test to detect antibodies to the HIV virus, the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS)?
___Yes ___No

Signature of patient or patient's representative _____

Printed name of patient or patient's representative _____ Date:_____

Representative's relationship to patient (POA, guardianship) _____

DOCUMENTATION OF SUCH RELATIONSHIP MUST BE COPIED AND PLACED IN PATIENT'S CHART