DES PLAINES POLICE PENSION FUND
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and Accountability Act (HIPAA)
(45 CFR Parts 160 and 164)

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Date of Birth: _____ Social Security Number: _____

I authorize _____ to release my health information to the Board of Trustees of the Des Plaines Police Pension Fund and its attorney, _____. I authorize the use or disclosure of the named individual's health information as described below for the purpose of seeking, maintaining, or terminating benefits from the Fund.

Information to be Released:

___ Entire medical record (to include ER records, admission and discharge summaries, dictated reports and consults, operative and procedure reports, intraoperative and procedure flow sheets, informed consents, physician orders, progress notes, nurses notes, flow sheets, medication and transfusion records, test results, labs, pictures, pathology reports, EKGs, fetal monitoring strips, office records, immunization records, growth charts, telemetry strips, radiology and other diagnostic reports, and patient instructions).

_____ Any and all

_____ Last five (5) years

_____ Other (specify) _____

___ Record abstract (history and physical, progress notes, lab, radiology, operative report, pathology report, consultation report, and diagnostic tests).

_____ Any and all

_____ Last five (5) years

_____ Other (specify) _____

___ Radiology and other diagnostic imaging films, pictures, and/or CD rom (x-rays, CT scans, MRI, ultrasound, angiogram, diagnostic procedure, etc.) unless otherwise specified.

_____ Any and all _____ Last five (5) years

____ Other (specify) _____

___ Pathology slides.
Describe: _____

___ Physical Therapy

___ All medical and related bills related to the above requested information.

I authorize the use or disclosure of the above named individual's health information as described below for the purpose of seeking, maintaining, or terminating benefits from the Fund. **The following items must be checked and initialed to be excluded from the use and/or disclosure of other health information:**

___ HIV / AIDS related treatment

___ Sexually transmitted diseases

___ Mental health

___ Drug / alcohol diagnosis, treatment / referral.

- I understand that I may revoke this authorization at any time, provided that I do so in writing to the Board of Trustees of Des Plaines Police Pension Fund, or its attorney, except to the extent that the records have already been released. Unless revoked earlier, this authorization will expire twelve (12) months from the date of signing or until (insert applicable date or event) _____ _____.

- I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal HIPAA privacy regulations, the information described above may be redisclosed and no longer protected by this regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

- I acknowledge that I have received a copy of this authorization.

- A photocopy of this authorization shall be as valid and effective as the original.

_____ _____
Signature of Applicant or Applicant's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

Subscribed and sworn to
before me this _____ day
of _____, _____

_____
Notary Public

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