



Authorization for Release of Patient Health Information

Patient Information:

Patient Name _____	Patient Date of Birth _____
Address _____	
City / State / ZIP _____	
Telephone # _____	

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From/To:	From/To:
Person / Institution _____	Person / Institution _____
Address _____	Address _____
City _____	City _____
State / ZIP _____	State / ZIP _____
Telephone # _____	Telephone # _____

I authorize the release of information covering the period(s) of healthcare from:

Date(s) _____	To date(s) _____
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The type of information to be used or disclosed is as follows:

<input type="checkbox"/> Abstract (documents summarizing health history)	<input type="checkbox"/> History and Physical Examination	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Diagnostic Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> X-Ray Images	<input type="checkbox"/> Verbal only (please specify) _____
<input type="checkbox"/> Other (please specify) _____		

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

<input type="checkbox"/> Genetic testing information and/or records	<input type="checkbox"/> Information about child abuse and neglect
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Patient 12 or over MUST AUTHORIZE this release by checking the box below and signing:

<input type="checkbox"/> HIV/AIDS related health information and/or records
<input type="checkbox"/> Behavioral or mental health information and/or records (Release must be witnessed, Patient 12 or over must authorize)
<input type="checkbox"/> Information about sexually transmitted disease
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Birth control
<input type="checkbox"/> Drug/alcohol diagnosis, treatment, and/or referral information

This information for which I'm authorizing disclosure will be used for the following purpose:

<input type="checkbox"/> My personal use (there is a fee for personal use copies)
<input type="checkbox"/> Sharing with other health care providers (no charge if sent directly to the provider – address must be provided as recipient above)
<input type="checkbox"/> Other (please specify) _____

This authorization will expire:

Date: _____, 20_____. If not otherwise specified, this release will expire within 30 days of the date of the signature.



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Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above. *For mental health purposes this authorization will expire one year from the date of signature.*

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Ann & Robert H. Lurie Children's Hospital of Chicago may refuse to treat me if I do not sign this Authorization.

I understand that once Lurie Children's discloses my health information to the recipient, Lurie Children's cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Lurie Children's Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that Lurie Children's may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Lurie Children's to use or disclose my health information in the manner described above.

Printed Name of Patient 18 or over or Legal Guardian	Relationship
Signature of Patient 18 or over or Legal Guardian	Date
Signature of Patient 12 or over	Date
Witness <i>(Mental health releases must be witnessed)</i>	Date
Interpreter (as applicable)	Date

For Lurie HIM Staff Only:

Signature of Lurie Children's Staff	Date
<small>(Lurie Children's Staff has checked the identification of the signer and ensured that this is the legal representative who has rights of access)</small>	