Ann & Robert H. Lurie
Children's Hospital of Chicago™
Health Information Management
225 E. Chicago Ave, Box 11
Chicago, IL 60611
Phone: 312.227.5220/Fax: 312.227.9733
roi@luriechildrens.org

3279P

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Authorization for Release of Patient Health Information

Section 1. Patient Information:

Patient Name _____ Patient Date of Birth_____

Address _____

City / State / ZIP _____

Telephone # _____

Section 2. I authorize the protected health information to be released as follows:

To be released from:	**To be given to/exchanged with:**
Person / Institution:	Person / Institution:
Address	Address
City/ State / ZIP	City/ State / ZIP
Telephone #	Telephone #
Email Address	Email Address

Section 3. Purpose: The purpose of this disclosure is:

- ☐ My personal use (there is a fee for personal use copies)
- ☐ Sharing with other health care providers (no fee if sent directly to the provider indicated above)
- ☐ Other (please specify):_____

Section 4. Format: Select one format of disclosure:

☐ Copy of Record – Mailed to address provided above in #2 ☐ Copy of Record to be picked up ☐ Verbal Release (e.g., phone conversation) ☐ Other: _____	Released electronically (select below): ☐ CD ☐ MyChart (must have an ACTIVE MyChart-mychart.luriechildrens.org) ☐ USB or Thumb Drive ☐ Email Secure Link (Radiology Imaging Only)

Section 5. Date Range: I authorize the release of information covering the period(s) of treatment:

From Date: _____ To date: _____

Section 6. The type of general health information to be used or disclosed is as follows (check all that apply):

☐ Abstract copy (Tests, results, typed reports) ☐ Consultation Reports ☐ Progress Notes ☐ History and Physical Examination ☐ Immunization history	☐ Operative Reports ☐ Radiology images ☐ Discharge Summary ☐ Diagnostic Reports	☐ Genetic testing information and/or records
☐ Other:		

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Section 7. Special Consent:
Certain types of highly sensitive information require a special indication from you, in order for us to release that information. Special consent is also required by adolescent patients aged 12-17 years old. Records may be reviewed by the provider prior to release. Providers have the right to deny release if deemed appropriate and in compliance with the law. The legal guardian and patient ages 12-17 must initial each item below for release, and sign at the end of the form:

Parent/Legal Guardian Initials	Type of Information	Patient ages 12-17 initials
	HIV/AIDS related health information and/or records	
	Sexually Transmitted Illness information and/or records	
	Sexual Assault/Abuse information and/or records	
	Birth Control information and/or records	
	Pregnancy information and/or records	
	Child Abuse/Neglect information and/or records	
	Behavioral and Mental health information and/or records	
	Drug/alcohol use information and/or records	
	Confidential Communication Note	

Legal Guardian Initials	Substance Use Treatment Information (42 CFR *Part 2*)	Patient ages 12-17 initials
	Chemical Dependency Assessments	
	Behavioral Health level of care assessments	
	Medication List	
	Laboratory Reports	
	Pathology Reports	

Section 8. Expiration

This authorization will expire on (insert date or event): _____.

If not otherwise specified above, this release will expire within six (6) months of the date of the signature.

Section 9. I understand and agree with the following:

- 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.
- Once the organization or person authorized to receive this information has received it, the information may be re-released by that organization or person. If this is the case, the information may no longer be protected by federal privacy laws; however, Illinois law does not allow the re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Confidentiality of Alcohol and Drug Abuse Patient Records Act and the Federal Confidentiality Rules, 42 C.F.R. Part 2, prohibit making any further disclosure of substance use disorder information unless further disclosure

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of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulation. All disclosures of substance use disorder treatment information are accompanied by a "*Notice to Individuals Receiving Alcohol, Drug Abuse and/or Mental Health Information,"* included below.

- I understand that I have the right to revoke (take back) this authorization at any time. I understand that if I wish to revoke this authorization, I must contact Lurie Children's Health Information Management Department to do so. 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.
- 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 *(Mental health releases must be witnessed)* *(Anyone other than parent or patient may witness)*	**Date**
Interpreter (as applicable)	**Date**

Notice to Individuals Receiving Substance Use (Alcohol, Drug Abuse) and/or Mental Health Information:
The confidentiality of alcohol and drug abuse patient records and/or mental health records disclosed to you pursuant to this authorization is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.

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