Ann & Robert H. Lurie
Children's Hospital of Chicago
ACHD Team
225 E. Chicago Avenue, Box 21
Chicago, IL 60611
Phone: 312-227-4403
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3279P

Authorization for Release of Patient Health Information

Patient Name _____

Patient Date of Birth _____

Address _____

City / State / ZIP _____

Telephone # _____

(for office use only) Medical Record # _____

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

From/To:

Person / Institution _____

Address _____

City _____

State / ZIP _____

From/To:

Person / Institution _____

Address _____

City _____

State / ZIP _____

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

Date(s) _____ To date(s) _____

The type of information to be used or disclosed is as follows:

☐History and physical examination ☐Discharge summary ☐Abstract (documents summarizing health history)

☐Consultation reports ☐Operative reports ☐Diagnostic reports (labs, x-rays, etc.)

☐Progress notes ☐X-Ray films ☐Verbal only (*please specify*)

☐Other (*please specify*) _____

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

☐HIV/AIDS related health information and/or records *(the patient 12 or over must authorize this release)*

☐Behavioral or mental health information and/or records *(release must be witnessed and the patient 12 or over must authorize this release)*

☐Information about sexually transmitted disease *(the patient 12 or over must authorize this release)*

☐Pregnancy *(the patient 12 or over must authorize this release)*

☐Birth control *(the patient 12 or over must authorize this release)*

☐Drug/alcohol diagnosis, treatment, and/or referral information *(the patient 12 or over must authorize this release)*

☐Genetic testing information and/or records

☐Information about sexual assault/abuse

☐Information about child abuse and neglect

☐Domestic abuse of an adult with a disability

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

☐My personal use (there is a fee for personal use copies)

☐Sharing with other health care providers (no charge if sent directly to the provider – address must be provided as recipient above)

☐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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Patient Name _____ Patient Date of Birth _____

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 form 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 or Legal Guardian:

_____

Signature of Patient or Legal Guardian: **Date/Time:**

_____ _____

(For information regarding Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Diseases, Pregnancy and Birth Control the patient 12 or over must sign to release these records)

If signed by Legal Guardian, relationship to patient: _____ **Date/Time:** _____

Interpreter (as applicable) _____ **Date/Time:** _____

For Mental Health Releases Only:

Witness: **Signature of Patient 12 or over:**

_____ _____

(Mental health releases must be witnessed)

Date/Time: _____ **Date/Time:** _____

(for office use only)

Signature of Lurie Children's Staff:

_____ **Date/Time:** _____

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