FRONT PAGE

Guardians: Please fill out the sections outlined in green. All areas outlined in red have been prefilled for you.

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
Authorization for Release of Patient Health Information

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

Authorization for Release of Patient Health Information

List your child's information here.

Patient Information:

Patient Name ______________________ Patient Date of Birth ______________

Address ______________________

City / State / ZIP ______________________

Telephone # ______________________

Name and contact information for your child's therapist, doctor, or school here.

Address information to Lurie Children's Hospital or Dr. Parkhurst here.

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) ______________

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

☐Abstract (documents summarizing health history) ☐History and Physical Examination ☐Discharge Summary
☐Consultation Reports ☐Operative Reports ☐Diagnostic Reports
☐Progress Notes ☐X-Ray Images ☐**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:

☐Genetic testing information and/or records ☐Information about child abuse and neglect

Patient 12 or over MUST AUTHORIZE this release by checking the box below and signing:

☐HIV/AIDS related health information and/or records
☐Behavioral or mental health information and/or records *(Release must be witnessed, Patient 12 or over must authorize)*
☐Information about sexually transmitted disease
☐Pregnancy
☐Birth control
☐Drug/alcohol diagnosis, treatment, and/or referral information

Information is prefilled for you. Nothing to fill out here.

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.

BACK PAGE

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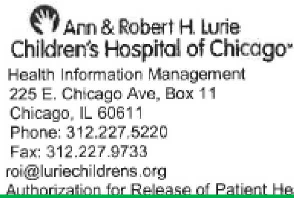

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Authorization for Release of Patient Health Information

Patient Name ______________________ Patient Date of Birth ______________

Unless revoked, this authorization will expire 30 days from the date of signature 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.

1. Please print and sign your name, relationship to patient, and todays date.

2. If patient is 12 or older, please have them sign as well.

3. Please find witness to co-sign release.

Printed Name of Patient or Legal Guardian	**Relationship**
Signature of Patient or Legal Guardian	**Date**

(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)*

For Mental Health Releases Only:

Signature of Patient 12 or over	**Date**
Witness *(Mental health releases must be witnessed)*	**Date**
Interpreter (as applicable)	**Date**

For Lurie HIM Staff Only:

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)