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

1. Patient Information:

Patient Name ______________________ Patient Date of Birth ____________

Address ______________________

City / State / ZIP ______________________

Telephone # ______________________

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

From:	**To:**
Person / Institution: Ann & Robert H. Lurie Children's Hospital of Chicago, Pritzker Department of Psychiatry and Behavioral Health	Person / Institution ____________
Address: 225 East Chicago Avenue	Address ____________
City: Chicago	City ____________
State / ZIP: Illinois 60611	State / ZIP ____________
Telephone #: 312-227-6650	Telephone # ____________

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

Date(s) ______________________ To date(s) ______________________

4. The type of 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
- ☐ Information about child abuse/neglect
- ☒ Other: Behavioral and Mental Health Information

5. Special types of information to be used or disclosed, requiring signature by patients age 12 and older (check all that apply):

- ☐ HIV/AIDS related health information and/or records
- ☐ Sexually Transmitted Illness information and/or records
- ☐ Birth Control information and/or records
- ☐ Pregnancy information and/or records
- ☒ Behavioral and Mental health information and/or records
- ☐ Drug/alcohol diagnosis and treatment

Substance Use Disorder treatment information and/or records (42 CFR *Part 2*):

- ☐ Chemical Dependency Assessments
- ☐ Behavioral Health level of care assessments
- ☐ Medication List
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Other:____________

6. 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):

- ☐ MyChart
- ☐ CD
- ☐ Other: ____________

7. 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 specificy):____________

8. Expiration:

This authorization will expire on: Date:__________, 20__.

If not otherwise specified, this release will expire within 30 days of the date of the signature. *For mental health purposes this authorization will expire one year form the date of signature.*

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

9. I understand 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 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 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 for more instruction on how 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 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.

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)