



**AUTHORIZATION FOR DISCLOSURE OF
CONFIDENTIAL HEALTH INFORMATION**

I, _____, whose birthdate is _____, do hereby authorize
_____ to release the following individually identifiable health information
(Name of Agency)

Please select box for all that apply:

- Immunizations only
- Most recent school/sports physical
- Progress Notes – Date(s) _____
- Lab Reports – Date(s) _____
- X-Ray Reports – Date(s) _____
- Consultations – Date(s) _____
- Hospital Notes – Date(s) _____
- Last ___ yrs. chart
- Other (specify) _____
- Original x-ray films with copy of report (my signature indicates that I assume responsibility to return original films within 14 days) Date of exam: _____

Confidential Disclosure:

I authorize release of the following highly confidential information (initial each item requested):

- _____ Mental health
- _____ Child abuse and neglect
- _____ Sexually transmitted disease
- _____ Substance abuse (i.e. alcohol or drugs)
- _____ Abuse of an adult with a disability
- _____ Sexual assault
- _____ HIV/AIDS testing or treatment

PURPOSE FOR NEED OF DISCLOSURE (Check all applicable categories):

- | | |
|--|--|
| Transfer of Care | <input type="checkbox"/> Treatment planning |
| <input type="checkbox"/> Relocation | <input type="checkbox"/> Consultation with physician |
| <input type="checkbox"/> Dissatisfaction with care | <input type="checkbox"/> Insurance qualification |
| | Other (Specify) _____ |

Name & address of person(s) or organization(s) requesting records, if different than patient:

Name & address of person(s) or organization(s) to receive the records:

- I wish to have the records copied, and I will pick them up at the facility.
- I am requesting that the facility copy the records and send the records to the above address.

Legal Authority for Request (please initial)

If you are not the patient, please specify your relationship to the patient and the legal basis on which authorization is given.

___ I am the patient's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical records. If a DPAHC is attached, then I have also included evidence that the patient's attending physician has determined that the patient has lost the capacity to make informed health care decision.

___ I am the patient's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

___ If the patient is deceased: I am the executor/administrator of the patient's estate, and I have attached to this authorization a valid appointment as such from a probate court.

___ The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.

___ The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the resident's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a power of attorney or probate court order.

Understandings & Agreements of Requestor

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, which will prevent disclosure of information. I understand that the above persons or organization authorized to make the requested disclosure may not condition treatment or payment upon completion of this form.
2. I understand that if I sign this authorization, I will be provided a copy of this authorization.
3. This authorization will expire _____ (90 days) from the date of my signature below.
4. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
5. I agree to waive all claims against the facility for the release of the requested information.
6. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
7. I understand that I must provide the facility with at least forty-eight (48) hours notice before coming to the facility to review records.
8. I understand that I have a right to inspect or copy the information to be used or disclosed.
9. I understand that after I have reviewed the records, I must provide the facility with forty-eight (48) hours advance notice of any copies of the records that I would like to pick up at the facility.
10. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
11. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records, which is cost-based pursuant to the HIPAA Privacy regulations: (a) the current cost per page for the copy paper; (b) the current cost per page for the toner; (c) cost of labor for copying, which is pro-rated based on the employee's pay and time it takes to make the copies; and (d) the actual cost of any postage incurred to send the copies via certified mail if mailing is requested.
12. The facility will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs.
13. I understand that the information in my health record may include information relating to sexually transmitted disease, genetic testing or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. _____

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Development Disabilities Act and/or under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records – no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.

Signature of person making request

Date

Printed Name of person making request

Witnessed By: _____

Date: _____