UChicago Student Wellness

AUTHORIZATION TO USE AND DISCLOSE INFORMATION BETWEEN UCHICAGO STUDENT WELLNESS AND THE UNIVERSITY OF CHICAGO MEDICINE

Section I: STUDENT/PATIENT INFORMATION

Student/Patient Name (last, first, middle initial):			
Birthdate:		Record Number:	
Address:			
City:	State:	Zip:	Phone:

The University of Chicago Organized Health Care Arrangement ("UC OHCA") consists of the University of Chicago Medical Center, portions of the University of Chicago that support the activities of health care, UCM Community Physicians, UCM Care Network Medical Group and Primary Healthcare Associates, SC.

Section II: RECIPIENT and PURPOSE

When I sign this Authorization, I will allow UChicago Student Wellness and the UC OHCA to use, disclose and share treatment, education, and health information with each other for the purpose of coordinating treatment and health care.

I understand the information to be disclosed is my entire UChicago Student Wellness record and my entire UC OHCA medical record, with the exception that in order to share the information listed below I must check the appropriate box. If that box is not checked, that information will not be shared without my consent, unless otherwise required or permitted by applicable law.

In addition, I specifically allow the following information to be disclosed under this Authorization:

- ❑ Information about a Mental Illness or Developmental Disability
- ❑ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ❑ Information about Communicable Diseases
- ❑ Information about Sexually Transmitted Infection(s)
- ❑ Information about Substance (i.e., alcohol or drug) Abuse
- ❑ Information about Abuse of an Adult with a Disability
- ❑ Information about Sexual Assault
- ❑ Information about Child Abuse and Neglect
- ❑ Information about Genetic Testing
- ❑ Information about Infertility/IVF/Artificial Insemination
- ❑ Information about Domestic Violence

Section III: EFFECTIVE DATE

This Authorization begins on _____ and it will remain in effect for one year.

*Provide a copy of Signed Authorization to Patient

I understand that once my health information is used, disclosed and shared between UChicago Student Wellness and the UC OHCA, UChicago Student Wellness cannot guarantee it will not be re-disclosed to a third party or otherwise disclosed as required or permitted by law.

I understand that any health information disclosed by UChicago Student Wellness to the UC OHCA will be treated as patient data by the UC OHCA and will be subject to the UC OHCA's policies relating to such patient data.

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except that, if my treatment is for the sole purpose of creating health information for disclosure to the recipient listed on the front of this Authorization, then UChicago Student Wellness may refuse to treat me if I do not sign this Authorization.

I may inspect or copy any information used/disclosed under this Authorization.

I understand that UChicago Student Wellness and the UC OHCA will not, directly or indirectly, receive any items of value from any third party in connection with the use or disclosure of the health information.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the Privacy Program (see the information below), and changing my mind will not affect my treatment. The revocation will not apply to the extent that UChicago Student Wellness, or the UC OHCA have already acted in reliance on this Authorization. This Authorization will remain in effect until revoked or, if earlier, until the date that is one year from the date on which I have signed below.

I have read and understand this Authorization, and I have had a chance to ask questions about the use, disclosure and sharing of the treatment, education or health information. I authorize UChicago Student Wellness, and each of the entities in the UC OHCA to use, disclose and share my health information in the manner described above.

_____	_____
*Signature of Patient or Personal Representative**	*Date*
_____	_____
Name of Personal Representative (If applicable)*	*Relationship to Patient*

**The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

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