THE UNIVERSITY OF CHICAGO MEDICINE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

*If the information is about a Mental Illness, Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Disease, Sexually Transmitted Disease, Alcohol or Drug Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse or Neglect, or Genetic Testing, then the patient **must** sign the Specific Consent Attachment.*

Section I: PATIENT INFORMATION

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

Section II: PURPOSE, INFORMATION, AND RECIPIENT

I authorize The University of Chicago Medicine to use or disclose the following health information during the term of this Authorization: (*check **all** that apply)*

- ❑ Clinic visit notes
- ❑ Emergency Room Report
- ❑ Surgical (operative report, path report)
- ❑ Hospitalization (H& P, Consult, Tests, Surgical, Disch Summary)
- ❑ X-ray Films (Please contact Radiology at 773-702-1788)
- ❑ Test results (Specify: Lab, X-ray, EKG, etc.)
- ❑ Complete Medical Record
- ❑ Billing records
- ❑ Therapy Notes (Specify: PT, Speech, Radiation, Chemo)
- ❑ Records related to a specific injury with the following date (e.g. workers' compensation injury): _____
- ❑ Photographs (please specify) _____
- ❑ Other : _____

_____

For the following dates of treatment: (for example: specific date 1/25/03; or range of dates Jan-July 2010; or all dates of service)

For the following purpose(s) (for example: training; workers' comp claim review; school requires immunization records; request of patient):

Section III: RECIPIENT:

The name of the person or class of persons to whom The University of Chicago Medicine may disclose my health information.

Name of Person:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip:	

I understand that The University of Chicago Medicine *will/will not (**circle one**),* directly or indirectly, receive any items of value from any third party in connection with the use or disclosure of the health information.

*Provide a copy of Signed Authorization to Patient

THE UNIVERSITY OF CHICAGO MEDICINE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

*If the information is about a Mental Illness, Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Disease, Sexually Transmitted Disease, Alcohol or Drug Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse or Neglect, or Genetic Testing, then the patient **must** sign the Specific Consent Attachment.*

PLEASE READ THIS PAGE CAREFULLY

Section IV: EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (*check one preference*)

- ❑ From the date of this Authorization until the following date: _____, 20__
- ❑ Until the purpose is fulfilled.
- ❑ Until the following event occurs: _____.
- ❑ Other: _____.

Note: The term for mental health records must be stated—you may not use "no expiration." If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

I understand that once my health information is disclosed to the recipient, neither The University of Chicago Medicine and entities in the University of Chicago Organized Health Care Arrangement ("UC OHCA") can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The UC OHCA consists of the University of Chicago Medical Center, portions of the University of Chicago that support the activities of health care, and UCMC Community Physicians. The third party may not be required to comply with this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

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 the UC OHCA may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that an entity in the UC OHCA 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 I may change my mind and revoke this authorization in writing at any time by notifying the HIPAA Program Office (see the information below), and changing my mind will not affect my treatment. The revocation will not apply to the extent that the University of Chicago Medicine or entities in the UC OHCA have already taken action where it relied on my permission.

I have read and understand this Authorization, and I have had a chance to ask questions about the use and disclosure of the health information. I authorize The University of Chicago Medicine and entities in the UC OHCA to use or disclose 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.*

University of Chicago Medicine HIPAA Program Office, MC1000, 5841 S. Maryland Ave., Chicago, IL 60637. Telephone: (773) 834-9716.

*Provide a copy of Signed Authorization to Patient

THE UNIVERSITY OF CHICAGO MEDICINE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Specific Consent Attachment

Patient Name (last, first, middle initial):	
Birthdate:	Medical Record Number:

SPECIFIC CONSENT

By checking any of the boxes next to a category of confidential information listed below, I specifically authorize the use and/or disclosure of the category of confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.

- ❑ Information about a Mental Illness or Developmental Disability
- ❑ Psychotherapy Notes (which are not part of the official medical record)
- ❑ 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 Disease(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

I have read and understand this Attachment, and I have had a chance to ask questions about the use and disclosure of the health information. I authorize The University of Chicago Medicine and entities in the UC OHCA to use or disclose the 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.*

***A witness signature is required for the release of information about a mental illness or developmental disability.*

Signature of Witness: _____ *Date:* _____

*Name of Witness:*_____

*Provide a copy of Signed Authorization to Patient