UI Health | UIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

INSTRUCTIONS: Please complete this Authorization in its entirety. You will be billed for copies of medical records according to the limits set by law unless the request is for continuation of care and the medical records are being released directly to another health care provider by the University of Illinois Hospital & Health Sciences System. Please address questions about this form to the Health Information Management (HIM) Department: 833 South Wood Street, Suite B-52, Chicago, IL 60612; Phone 312-996-3350; Fax 312-413-2822.

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL INFORMATION RELEASED TO:

Individual/Organization: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

MEDICAL INFORMATION REQUESTED FROM:

_____

_____

_____

_____

_____

PURPOSE OF THE DISCLOSURE:

☐ Continuation of Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability ☐ School

☐ Other: _____

METHOD OF DELIVERY:

☐ Mail ☐ Fax

☐ Electronic Delivery (encrypted e-mail, secure portal). Provide e-mail address: _____

☐ Pick up by the Patient or _____ (Specify Individual). A photo ID is required to pick up records.

INFORMATION REQUESTED:

☐ Abstract Only (History & Physical, Discharge Summary, Operative/Procedure Reports, Consultations, Clinic Visit Notes, Radiology/Pathology/Lab Reports)

☐ Entire Medical Record (Images are NOT included)

☐ Other Medical Records (e.g., ED, Clinic Visit Notes, Hospital Stay, Immunizations): _____

☐ Radiology	☐ Reports	☐ Images		Dates: _____
☐ Pathology	☐ Reports	☐ Slides	☐ Other _____	Dates: _____
☐ Ophthalmology	☐ Reports	☐ Images		Dates: _____
☐ Dental Records	☐ Reports	☐ Images		Dates: _____

For Medical Records Billing, contact Patient Accounts at 312.996.1000 or send an email to billinfo@uic.edu
For Dental Records Billing, contact Dental Billing Office at 312.996.3571 or send an email to codbilling@uic.edu

SENSITIVE MEDICAL INFORMATION TO BE RELEASED
(Patient or Patient Representative must initial and date each item authorized for release.)
I understand that the records requested may include sensitive medical information that requires my specific authorization for release. By initialing below, I specifically authorize the release of the following information:

☐ Mental Health/Developmental Disabilities	Initials: _____	Date: _____
☐ Substance Use Disorder (SUD) and Treatment	Initials: _____	Date: _____
☐ Alcohol or Drug Use/Abuse	Initials: _____	Date: _____
☐ AIDS/HIV, including HIV test results	Initials: _____	Date: _____
☐ Genetic Testing and Genetic Information	Initials: _____	Date: _____
☐ Sexually Transmitted Diseases	Initials: _____	Date: _____
☐ Communicable Diseases	Initials: _____	Date: _____
☐ Child Abuse and Neglect	Initials: _____	Date: _____

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

- I understand that this authorization is voluntary and I may refuse to sign it. If I do not sign this authorization, the requested use or disclosure of my protected health information described in this authorization will not occur. I understand that my treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on whether I sign this authorization unless otherwise permitted by law.
- I understand that I may revoke this authorization at any time by providing written notice to the Privacy Officer or Health Information Management Department. Revocation will not affect any use or disclosure made before my written revocation was received.
- I understand that I have the right to receive a copy of this signed authorization.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws.
- I understand that this authorization expires ninety (90) calendar days after the date I sign it.

MINOR PATIENTS (12–17 YEARS OF AGE)

Illinois law provides certain confidentiality protections for medical information of minor patients who have the legal authority to consent to their own care.

For minor patients ages 12–17, records related to services that the minor was legally permitted to consent to independently (including certain services involving substance use, HIV/AIDS, sexually transmitted infections, reproductive health, sexual assault, or other protected services) may require the minor patient's authorization before disclosure.

A parent or legal guardian's signature alone may not authorize release of these records when the minor has legally consented to the underlying care.

Mental health and developmental disability records involving minor patients may have additional confidentiality requirements under applicable Illinois law. Additional authorization or documentation may be required before these records can be disclosed.

SIGNATURES:

Printed Name of Patient or Patient Representative		**Date/Time**
Signature of Patient or Patient Representative	**Relationship to Patient**	**Date/Time**

If signed by someone other than the Patient, please state the Representative's relationship to the Patient and/or the Representative's legal authority to act on the Patient's behalf (e.g., parent, legal guardian, health care surrogate, health care power of attorney, etc.). Documentation of the Representative's authority (e.g., court order, legal guardianship, power of attorney, etc.) must be attached if the Patient is not signing this authorization.