UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System

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:

☐ Physician/Organization for Continuation of Care ☐ Personal Use ☐ Legal

☐ Other (Specify): _____

METHOD OF DELIVERY:

☐ By US Mail

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

☐ At HIM Department ☐ Other Location (Specify): _____

☐ By Secure Electronic Delivery Through a Third-Party Internet Portal

E-mail address: _____ (Excludes Radiology Images)

INFORMATION REQUESTED:

☐ Abstract Only (Most Recent History & Physical, Discharge Summary, Operative Reports, Pathology Reports, Consultation Reports, Clinic Notes, Radiology Reports, Lab Reports)	☐ Inpatient Dates: _____
☐ Entire Medical Record	☐ Emergency Room Dates: _____
☐ Other (Specify): _____	☐ Outpatient/Clinic Dates: _____
	☐ Radiology Reports Dates: _____
	☐ Radiology Images (CD or Film) Dates: _____

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Patient or Patient Representative Initial and Date Required for Each Item):
I understand that the records requested above may contain sensitive medical information that requires my specific consent in order to be released. I specifically authorize the release of the following sensitive medical information:

☐ Mental Health/Developmental Disabilities Initials _____ Date _____

☐ Drug/Alcohol Use Initials _____ Date _____

☐ AIDS/HIV Initials _____ Date _____

☐ Genetic Testing Initials _____ Date _____

0404EA

Original - HIM Department **Yellow Copy - Requestor** UI-0404EA (4-15)

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

- I understand that this authorization is voluntary and I may refuse to sign it. The immediate consequences of my refusal will be that the University of Illinois Hospital & Health Sciences System will not receive or release the medical information listed above through this authorization. I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that I may revoke this authorization, at any time, by notifying the HIM Department in writing at the address listed above. I understand my written revocation is effective only when the HIM Department receives it. I understand that my later decision to revoke this authorization will not affect any action, use, or disclosure in reliance on this authorization, which cannot be reversed.
- I understand I have the right to inspect and/or receive a copy of the medical information listed above and also receive a copy of this authorization form.
- I understand that medical information disclosed through this authorization may no longer be protected by federal health information privacy laws. I also understand that sensitive medical information (identified above) disclosed through this authorization may require my additional authorization to be further disclosed.
- I understand this authorization will terminate ninety (90) days after my date of signature and will not be able to be disclosed beyond this date.

MINOR PATIENTS 12 – 17 YEARS OF AGE:

Please note that the following medical information of a Patient 12 – 17 years of age (Minor Patient) is restricted as follows: Drug/alcohol use, AIDS/HIV, or Birth Control/Sexually Transmitted Disease(s)/Sexual Assault, as well as any health information generated as a result of the Minor Patient's independent legally-authorized consent to treatment, requires the Minor Patient's signature to this release.
Mental health or developmental disabilities information is available after the Minor Patient's signature has been witnessed or the Minor Patient's parent or guardian's signature has been witnessed, provided the Minor Patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor Patient's parent or guardian.

SIGNATURES:

_____ _____
Signature of Patient or Patient Representative **Date/Time**

_____ _____
If Signed by Other than the Patient: PRINT Patient Representative's Name **Phone Number**

_____
If signed by other than the Patient, please state the Representative's relationship with the Patient and/or the authority of Representative to request information on behalf of the Patient (e.g., Parent, Legal Guardian, Identified Health Care Surrogate, Health Care Power of Attorney, etc.).

WITNESS: Please note that a signature of a witness who can attest to the identity of an authorized signatory is required to release any mental health or developmental disabilities information or to revoke any previous authorizations, regardless of the Patient's age. The witness cannot be the same person as the authorized signatory.

_____ _____
Signature of Witness **Date/Time**

_____ _____
PRINT Witness Name **Phone Number**

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