2001 S. California Ave.
Chicago, IL 60608
Phone: 773-584-6200 • Fax: 773-376-8840

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to ____

release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: ________ Zip Code: ____________

Phone: ______________________ Fax: ______________________

As a patient you have the right to revoke the authorization in writing and a description by informing the facility. You have the right to inspect and copy your information at any moment. If you decide to refuse to consent and sign the release of information then the consequences will be that the authorization is no longer valid. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________
____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Redisclosure prohibited: Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written contact of the patient. If released or re-disclosed for other reasons then personal records are no longer protected by HIPAA fedral Law. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental treatment without further authorization.

Patient Signature: ______________________ Date Signed: ______________________

Witness Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED