AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: EDUCATION

If the information is about a Mental Illness, Developmental Disability, HIV/AIDS Testing or Treatment Communicable Disease, Venereal 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.

Patient's Name: _____
Last First Middle

Medical Record Number: _____ **Date of Birth:** _____

Home Address: _____

The UC Organized Health Care Arrangement (or **UC OHCA**) consists of University of Chicago Medical Center, certain activities of the University of Chicago including the physicians, and the UCMC Community Physicians LLC. ** Each of these is called a **UC Organization**.

I UNDERSTAND THAT UCMC IS A TEACHING HOSPITAL. AS PART OF ITS EDUCATIONAL MISSION, PHYSICIANS AND OTHER EMPLOYEES GIVE EDUCATIONAL SESSIONS WITHIN THE HOSPITAL, SCHOOL OF MEDICINE, UNIVERSITY, AND AT PUBLIC EVENTS.

PURPOSE: When I sign this Authorization, I will allow the UC Organizations to use and disclose the health information listed below for the following purpose (*check those that apply*):

☐ create and present one or more case study(ies).
☐ create and present one or more live classes, webinars, and seminars.
☐ create and publish one or more article(s), textbooks, internet publications, or other publications.
☐ create and present hard copy and electronic materials such as PowerPoint slides, handouts, training tools, including on the Internet.
☐ Other (*be specific*): _____.

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes (*be specific*):

_____ Description of injury or condition
_____ Clinical History
_____ Family History
_____ Patient demographics (age, sex, etc.)
_____ Test Results
_____ Patient diagnosis
_____ Patient treatment
_____ Other (*be specific*) _____
_____.

_____ By putting my initials here, I give my **permission to use and disclose photograph(s), videotape(s) or audiotape(s) or other images of me**, with or without my name, for the purposes listed on this Authorization.

RECIPIENT: The following are the people to whom the UC Organizations may disclose my health information:

☐ attendees at a public conference(s), seminar(s), or other educational session(s).
☐ publishers and readers of a publication(s).
☐ health care providers at the following type of gatherings (*be specific*):_____.
☐ Other (*be specific*): _____.

I understand that the UC Organizations *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.

TERM: This Authorization will remain in effect with no expiration, although I can revoke the authorization if I change my mind by notifying the Privacy Office (see below). Changing my mind will not affect my treatment. The revocation will not apply to information already used and disclosed.

***Provide a copy of signed Authorization to Patient**

I understand that once the health information is disclosed to the recipient, neither UCMC nor any of the other UC Organizations can guarantee that the recipients will not redisclose the health information to third parties or as required by law. The third parties may not be required to comply with this Authorization or applicable federal and Illinois law governing the use and disclosure of the 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 Organization 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 a UC Organization 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 have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize each UC Organization 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.*

HIPAA Privacy Program, Office of Corporate Compliance, The University of Chicago Medical Center and Biological Sciences Division, MC-1000, 5841 South Maryland Avenue, (MC 1000) | Chicago, IL 60637, Telephone Number: (773) 834-3853

Last Updated September 9, 2015

***Provide a copy of signed Authorization to Patient**

SPECIFIC CONSENT
ATTACHMENT

Patient's Name: _____
Last First Middle

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 Venereal 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

I have read and understand the terms of this Attachment and I have had a chance to ask questions about the use and disclosure of the confidential information. I authorize each UC Organization to use or disclose the confidential information checked above in the manner described above.

_____ _____
Signature of Patient or Personal Representative *Date*

_____ _____
Name of Personal Representative (if applicable)* *Relationship to Patient*

Witness' Signature required for release of information about a mental illness or developmental disability

Signature of Witness:_____

***Provide a copy of signed Authorization to Patient**