PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
DISCLOSURE TO THE UNIVERSITY OF CHICAGO

If the information is about a Mental Illness, Developmental Disability, Communicable Disease, Venereal Disease, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse or Neglect, Genetic Testing, Domestic Abuse, or Artificial Insemination, then the patient must review the Specific Consent section.

Patient's Name: ____
Last First Middle

Home Address: ____

Home Telephone: ____________________ **Date of Birth:** __________

The UC Organizations consists of The University of Chicago Medical Center (UCMC) and certain activities of The University of Chicago including the physicians.

PURPOSE: When I sign this Authorization the ______________________________________
(*insert name of institution or provider*) ("Provider") may disclose the listed below, to the UC Organization(s) the information below for the following purpose [*Note:"at the request of the patient" is sufficient if the patient is initiating this Authorization*]:

☐ to share my care and treatment records with another health care provider, which is named below.
☐ other____

For disclosure to the following UCMC Provider: (Provider Name, Address , Telephone and/or Fax)

SPECIFY INFORMATION TO BE DISCLOSED BELOW:

For the following dates of treatment: (for example: specific date 1/25/03; range of dates Jan~July 2001; all dates of service)

Categories of Mental Health Information to be Disclosed: **(check all that apply)**

☐ Information about a Mental Illness or Developmental Disability
☐ Psychotherapy Notes
☐ 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 Substance Abuse
☐ Information about Physical Abuse or Neglect
☐ Information about Sexual Assault

Documents to be Disclosed:

☐ **Complete Mental Health Record** (Including types of information that I have checked above to be released)

-OR-

Specific Documents of the Mental Health Record Only: **(check all that apply)**
☐ Clinic Notes
☐ Psychological Testing Final Report
☐ Medication Ordered/Given
☐ **Other:** ______________________
____

General Information to be Disclosed:
(check all that apply)

☐ Clinic Visit Notes
☐ Emergency Room Report
☐ Surgical Report (operative, pathology)
☐ Hospitalization (H&P, Consultations, Tests, Surgeries, Discharge Summary)
☐ X-ray Films
☐ Test Results (Specify: Lab, X-Ray, EKG, etc.)
☐ Therapy Notes (Specify: PT, Speech, Radiation, Chemotherapy, ect.)
☐ Records Related to a Specific Injury with the Following Date (e.g. workers' compensation injury):
____
____

☐ Other____________________

-OR –

Complete Medical Record Options:
☐ Every Page in Medical Record
☐ Summary Abstract of Medical Record includes…______________________
____
____

***Provide a copy of signed Authorization to Patient** June 2010

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SPECIFIC CONSENT:
By checking any of the boxes below, I am specifically authorizing the UC Organization(s) to use and/or disclose the category of confidential information indicated next to the box, if applicable 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
- ☐ Information about Domestic Abuse
- ☐ Information about Artificial Insemination

I understand that once my Provider discloses my health information to any of the UC Organization(s), my Provider does not guarantee that the UC Organizations will not redisclose the health information to a third party or as required by law. The UC Organizations 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 from the Provider or payment or my eligibility for benefits. If my treatment is for the sole purpose of creating health information for disclosure to the UC Organizations, then the Provider 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 Provider, and changing my mind will not affect my treatment. The revocation will not apply to the extent that any Provider has already taken action where it relied on my permission.

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 the Provider to use or disclose my health information in the manner described above.

___________________________________ ____________________
Signature of Patient *Date*

____________________/_________________________ ________________ ____________________
*Signature /Printed Name of Personal Representative** *Date* *Relationship to Patient*
(if applicable)

** 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.*

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** June 2010