THE UNIVERSITY OF CHICAGO MEDICINE

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

*Witness signature line **must** be signed for your request to be processed.*

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birthdate:		Medical Record Number:	
Address:			
City:	State:	Zip:	Phone:

The University of Chicago Organized Health Care Arrangement ("UC OHCA") consists of the University of Chicago Medical Center, the UC Pediatric Specialty Clinics, University of Chicago Physicians Group, and UCMC Community Physicians, LLC, and portions of the University of Chicago that participate in or support the activities of health care.

Section II: PURPOSE and INFORMATION to be DISCLOSED

When I sign this Authorization, I will allow the UC OHCA to disclose the health information listed below for the following purpose:

- ❑ To share my care and treatment records with another health care provider, which is named below.
- ❑ Other: _____

Information to be Disclosed (*check **all** that apply)*

Types of Information to be Disclosed:

- ❑ 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

Psychotherapists' personal notes and psychological tests are not available.

Dates of Service: _____

Documents to be Disclosed:

- ❑ Complete Medical Record (including types of information that I have checked to be released)

-OR-

Documents of the Mental Health Record Only:

- ❑ Clinic Notes
- ❑ Psychological Testing Final Report
- ❑ Medication Ordered/Given
- ❑ Other: _____

_____

- ❑ We may have received mental health information from another of your mental health providers. Check here if we may disclose this information as well.

Section III: EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (*check one preference*)

- ❑ From the date of this Authorization until the following date: _____, 20__
- ❑ Until the purpose is fulfilled.
- ❑ Until the following event occurs: _____.
- ❑ Other (e.g. no expiration): _____.

Note: The term for mental health records must be stated—you may not use "no expiration." If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

*Provide a copy of Signed Authorization to Patient

Section IV: RECIPIENT:

The name of the person or class of persons to whom The University of Chicago Medicine may disclose my health information.

Name of Person:	Phone Number:
Name of Organization:	
Street Address:	
City, State, Zip:	
I understand that The University of Chicago Medicine *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.	

I understand that once my health information is disclosed to the recipient, neither The University of Chicago Medicine and entities in the University of Chicago Organized Health Care Arrangement ("UC OHCA") can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party 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 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 OHCA 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 an entity in the UC OHCA 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 HIPAA Program Office (see the information below), and changing my mind will not affect my treatment. The revocation will not apply to the extent that the University of Chicago Medicine or entities in the UC OHCA have already taken action where it relied on my permission.

I have read and understand this Authorization, and I have had a chance to ask questions about the use and disclosure of the health information. I authorize The University of Chicago Medicine and entities in the UC OHCA 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.* ***Please note that Illinois law allows a patient 12 years and older to sign this form as the patient.*

A witness signature is required for the release of information about a mental illness or developmental disability.

Signature of Witness: _____ *Date:* _____

*Name of Witness:*_____

Mail completed form to: *University of Chicago Medicine, Dept. of Psychiatry, ATTN: Medical Records, 5841 S. Maryland Ave., MC 3077, Chicago, IL 60637* **or** *Fax to: ATTN: Psychiatry Medical Records, (773) 702-6454*

University of Chicago Medicine HIPAA Program Office, MC1000, 5841 S. Maryland Ave., Chicago, IL 60637. Telephone: (773) 834-9716.

*Provide a copy of Signed Authorization to Patient