AUTHORIZATION TO USE AND DISCLOSE
HEALTH INFORMATION FOR DISABILITY DETERMINATION

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.

A patient label may be placed here:

Patient's Name: _____
Last First Middle

Medical Record Number: _____

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

The UC Organized Health Care Arrangement (or **UC OHCA**) consists of University of Chicago Medical Center (UCMC) and certain activities of the Unive rsity of Chicago including the physicians .

Each of these is called a **UC Organization**.

PURPOSE: By signing this Authorization, I will allow the UC Organizations to disclose the health information listed below for the following purpose(s):
☐ Confirm the need for leave of absence ☐ Determination of Disability
☐ Other (*specify*): _____.

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:
☐ The following (*specify*): _____.

RECIPIENT: The following is the name and address of the person or the class of persons (e.g. HR Director) to whom the UC Organizations may disclose the health inform ation:

_____

_____.

I understand that UCMC may be paid for the screening/evaluation or other services requested by the employer, but it will not, directly or indirectly, receive any other items o f value from any third party in connection with the use or disclosure of the health information.

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the following date: _____, 200___.
☐ Until the purpose is fulfilled .
☐ Until the following occurs (e .*g. if I write to UCMC stating that I no longer work for this employer*):

_____.
☐ Other (e.g. no expiration): _____.

Note: The Term for mental health records must be stated—you may not use "no expiration."

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

I UNDERSTAND THAT IF I DO NOT SIGN THIS AUTHORIZATION, UCMC MAY DETERMINE THAT IT CANNOT DISCLOSE THE HEALTH INFORMATION, AND I MAY NOT RECEIVE CERTAIN BENEFITS. UCMC CANNOT PROVIDE ME WITH INFORMATION ABOUT MY BENEFITS.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. IF THE PURPOSE OF THE SERVICES IS TO PROVIDE HEALTH INFORMATION TO THE RECIPIENT, THEN UCMC MAY REFUSE THESE SERVICES. IF THE TREATMENT IS RELATED TO PARTICIPATION IN A RESEARCH STUDY, I UNDERSTAND THAT A UC ORGANIZATION MAY REFUSE TREATMENT IF I DO NOT SIGN THIS AUTHORIZATION.

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 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 the health information.

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 Privacy Office (see the information below). Changing my mind may affect the services I receive, as stated above. The revocation will not apply to the extent that any UC Organization 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 each UC Organization to use or disclose the 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.*

UC OHCA Privacy Office: University of Chicago Medical, MC -1000, 5801 South Maryland Avenue, Chicago, IL 60637, Telephone Number: (773) 834-9716

Last Updated January 7, 2010

***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 reco rd)

☐ 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 ab ove 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**