

I UNDERSTAND THAT IF I DO NOT SIGN THIS AUTHORIZATION, UCH MAY DETERMINE THAT IT CANNOT DISCLOSE THE HEALTH INFORMATION, AND I MAY NOT RECEIVE CERTAIN BENEFITS. UNIVERSITY OF CHICAGO HOSPITALS 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 UCH 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 UCH 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

\\HIPAA\Implementation\Policies and Forms\Specific Authorization Forms\Authorization disability determination.doc

Last Updated May 22, 2003

**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**