

**AUTHORIZATION TO USE AND DISCLOSE YOUR HEALTH INFORMATION
AND RULES THAT APPLY TO YOUR DUOLA**

You have requested to have a Duola with you during your labor and child birth. Of course, during this process the Duola will access to your health information. In addition, the University of Chicago Hospitals (UCH) imposes certain rules to help protect you from harm. By signing this form, you agree that the Duola may receive your health information and you agree to the rules that apply to your Duola.

UCH was not involved in your choice of the Duola. Please note that Duolas are not licensed by the state and are not required to receive any special training. Your physician is responsible for providing your care, not the Duola.

UCH may at any time ask your Duola to leave an area if it in any way believes that the Duola's presence may affect the care we are providing you.

Note: If the information sought is about a Mental Illness or Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Diseases, Venereal Disease(s), Substance (i.e., alcohol or drug) Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse and 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 Hospitals, certain activities of the University of Chicago including the physicians, the UCHHS Regional Doctors Offices, and Friend Family Health Care Clinic in Hyde Park.

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

The Duola will have access to all health information disclosed during any that she is present [*anything else—specify anything she might have access to—can she read the medical record? Can she ask question of the nurses, etc.?*]

Your Duola's name and address is: _____

TERM: This Authorization will remain in effect:

From the date of this Authorization until the following date: _____, 200__.

Until purpose is fulfilled.

Until the following event occurs (e.g. after the specific fundraising program is over):

 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 once my health information is disclosed to the Duola, neither UCH nor any of the other UC Organizations can guarantee that she will not redisclose the health information to a third party or as required by law. The Duola 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 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 understand that UC Organizations will not, 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 I may change my mind and revoke this authorization in writing at any time by notifying the Privacy Office (see the information below), and changing my mind will not affect my treatment. 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 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.*

Privacy Office: University of Chicago Medical Center, MC-1000, 5841 South Maryland Avenue, Chicago, IL 60637, Telephone Number: (773) 834-9716

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HIPAA\Implementation\Policies and Forms\Specific Authorization Forms\Authorization for Duola.doc

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: _____