

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: EDUCATION**

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.

**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**.

**PURPOSE:** When I sign this Authorization, I will allow the UC Organizations to use and disclose the health information listed below for the following purpose (*check those that apply*):

- create and present one or more case study(ies).
- create and present one or more presentation(s).
- create and publish one or more article(s), textbooks, internet publications, or other publications.
- Other (*be specific*): \_\_\_\_\_.

**SPECIFY INFORMATION TO BE DISCLOSED:** The information that may be disclosed under this Authorization includes (*be specific*):

- |  |   |
|--|---|
| _____ Description of injury or condition | _____ Clinical History                      |
| _____ Family History                     | _____ Patient demographics (age, sex, etc.) |
| _____ Test Results                       | _____ Patient diagnosis                     |
| _____ Patient treatment                  |   |
| _____ <b>Other:(explain)</b> _____       |   |

\_\_\_\_\_ By putting my initials here, I give my **permission to use and disclose photograph(s), videotape(s) or audiotape(s) or other images such as an MRI of me**, with or without my name, for the purposes listed on this Authorization.

**RECIPIENT:** The following are the people to whom the UC Organizations may disclose my health information:

- attendees at a public conference(s), seminar(s), or other educational session(s).
- publishers and readers of a publication(s).
- health care providers at the following type of gatherings (*be specific*):\_\_\_\_\_.
- Other (*be specific*): \_\_\_\_\_.

I understand that the UC Organizations *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.

**TERM:** This Authorization will remain in effect:

- From the date of this Authorization until the following date: \_\_\_\_\_, 200\_\_.
- Until the following event occurs (e.g. after the conference 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 the health information is disclosed to the recipient, neither UCH nor any of the other UC Organizations can guarantee that the recipients will not redisclose the health information to third parties or as required by law. The third parties 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 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 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.*

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

Last Updated August 26, 2003, 2003

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## 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:** \_\_\_\_\_