**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION TO THE ESTATE**

*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 Medical Center (UCMC) and certain activities of the University of Chicago including the physicians .

**PURPOSE:** I am the executor/administrator (*circle one*) of the estate of the Patient named above. When I sign this Authorization, I will allow the UC Organizations to disclose the Patient's health information listed below for the following purpose [ *Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization*]:

_____

_____.

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

_____

_____.

**RECIPIENT:** The following is the name of person or the class of persons to whom the UC Organizations may disclose my health information:

The address of the recipient or where my health information will be delivered is:

_____.

I understand that the 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.

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

☐ From the date of this Authorization until the following date: _____, 200___.
☐ Until the purpose is ful filled.
☐ 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 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 understand that I may refuse to sign this authorization and that my refusal to sign will not affect the Patient's ability to obtain treatment or payment or my eligibility for benefits except that.

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 the Patient's 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 Executor or Administrator* *Date*

_____

*Name of Executor or Administrator*

***The legal document appointing the Executor or Administrator must be attached to this form.***

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

Last Updated September 22, 2009

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***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 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 Executor or Administrator* *Date*

_____
*Name of Executor or Administrator*

***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**