AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: OBSERVERS

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 and certain activities of the University of Chicago in cluding the physicians.

PURPOSE: When I sign this Authorization, I will allow the UC Organizations to disclose the heal th information listed below for the purpose of allowing the individual listed below to observe clinical care in process. This person is not a student in an educational program sponsored by any UC Organization.

SPECIFY INFORMATION TO BE DISCLOSED: The in formation that may be disclosed under this Authorization includes:

☐ All information discussed during the time the observer is present during my treatment and evaluation.
☐ All information in my medical record.
☐ A short summary of my condition and treatmen t outside of my presence.
☐ Other (*be specific*):_____.

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 disclosed to is:

_____.

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 purpose is fulfilled.
☐ Until the following event occurs (e.g. after the specific fundrai sing 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 UC MC 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 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 t his 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 t o 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, 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 o r 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 th at 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**