

I understand that once my health information is disclosed to the Dean on Call and/or the Housing Department, the hospital cannot guarantee that the Dean on Call and/or Housing Department will not redisclose the health information to a third party or as required by law. While the Dean on Call and/or Housing Department may not be required to comply with this Authorization, applicable laws govern their use of student information, which may include my health information. I understand that I can discuss this with the Dean on Call and/or Housing Department.

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 Health Care Provider 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 Health Care Provider 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.*

Witness' Signature required for release of information about a mental illness or developmental disability

Signature of Witness

Date

Name of Witness

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