AUTHORIZATION TO USE AND DISCLOSE STUDENT HEALTH INFORMATION TO UNIVERISTY OF CHICAGO ADMINISTRATION

Patient's Name: ____
Last First Middle
Medical Record Number: ________________________ **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. Each of these is called a **UC Organization.**

RECIPIENT AND PURPOSE: When I sign this Authorization, I will allow my physicians and the staff of the UC Organizations to disclose the health information listed below to the (*check all that apply*):

☐ University of Chicago's Dean on Call Dean's Office
☐ University of Chicago Housing Department

For the purpose of (*check all that apply*):

☐ assisting me with my care at UCMC
☐ assisting me with my transition back to campus and classes, to access relevant community services, and, if I am a resident of U of C housing, for housing

THE INFORMATION TO BE DISCLOSED: The following information may be disclosed under this Authorization:
☐ the fact that I am in the hospital
☐ my expected discharge date
☐ my discharge plan
☐ allow the Dean on Call to visit me
☐ my medical condition

In addition, I specifically allow the following information to be disclosed under 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
☐ Information about Artificial Insemination
☐ Information about Domestic Violence

TERM: This Authorization will remain in effect until the purpose is fulfilled.

Last Updated January 6, 2010
***Provide a copy of signed Authorization to Patient**

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 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.*

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

_______________________________________ _____________________

Signature of Witness *Date*

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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

***Provide a copy of signed Authorization to Patient**