Chicago Family Asthma & Allergy, S.C.
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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION:

Patient Name _____
Patient Date of Birth_____
Address_____
City / State / Zip _____
Telephone #_____ Fax #_____

I hereby authorize the protected health information regarding the above named person to be exchanged between:

From:	**To:**
Person/ Institution_____	Person/Institution_____
Address_____	Address _____
Address_____	Address _____
City/State/Zip_____	City/State/Zip _____
Phone/Fax_____	Phone/Fax_____

I authorize the release of information covering the period(s) of healthcare from:
Date _____ To Date _____

The type of information to be used or disclosed is as follows:

- ☐ History and physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Diagnostic tests (labs, x-rays, skin tests)
- ☐ Verbal only (please specify) _____
- ☐ Other (please specify) _____

The following confidential items must be checked off to be included in the use or disclosure of other health information:

- ☐ HIV/AIDS related information and/or records (patient 12 or over must authorize release)
- ☐ Behavioral or mental health information and/or records
- ☐ Information about sexually transmitted disease (patient 12 or over must authorize release)
- ☐ Pregnancy (patient 12 or over must authorize release)
- ☐ Birth control (patient 12 or over must authorize release)
- ☐ Drug/alcohol diagnosis and/or treatment information (patient 12 or over must authorize)
- ☐ Genetic testing information and/or records
- ☐ Information about sexual assault/abuse
- ☐ Information about child abuse and neglect
- ☐ Domestic abuse of an adult with disability

This information for which I am authorizing disclosure will be used for the following purpose:

- ☐ My personal use (there is a fee for personal use copies)
- ☐ Sharing with other health care providers (no charge if sent directly to the provider)
- ☐ Other (please specify)_____

This authorization will expire date: _____, 20_____. If not otherwise specified this release will expire within 30 days of the date of signature.

AUTHORIZATION FOR PATIENT RELEASE OF HEALTH INFORMATION:

Patient Name_____ Patient Date of Birth_____

Unless revoked, this authorization will expire within 30 days from the date of signature on the authorization or from the date noted above. For mental purposes this authorization will expire one year from the date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except however, if my treatment is for the sole purpose of creating health information for disclosure for the recipient identified in the authorization, in which case Chicago Family Asthma & Allergy, SC may refuse to treat me if I do not sign this authorization.

I understand that once Chicago Family Asthma & Allergy, SC discloses my health information to the recipient, Chicago Family Asthma & Allergy, SC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Chicago Family Asthma & Allergy, SC. I understand that the revocation will not apply to the information that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I understand that Chicago Family Asthma & Allergy, SC may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or The Confidentiality of Alcohol and Drug Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized the disclosure specifically authorizes a re-disclosure.

I understand that I have the right to inspect and obtain a copy of the information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this authorization.

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Chicago Family Asthma & Allergy, SC to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian:

_____

Signature of Patient or Legal Guardian: Date:

_____ _____

(For information regarding Mental Health, HIV/AIDS, Sexually Transmitted Diseases, Pregnancy and Birth Control: the patient 12 or over must sign to release these records)

If signed by Legal Guardian, relationship to patient:_____ Date:_____