Lurie Children's Primary Care
Town & Country Pediatrics
Medical Records Department
Phone: (312) 279-8913
Fax: (312) 337-2354
E-Mail: TCPrecords@luriechildrens.org

3 2 7 9 P

Medical Record No.
Patient Name
Birthdate
Physician
*Please align patient label to the right*

Authorization for Release of Patient Health Information

# Authorization for Release of Patient Health Information

**Patient Information:**

Patient Name _____ Patient Date of Birth_____

Address _____

City / State / ZIP _____

Telephone # _____

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

| **From/To:** | **From/To:** |
|---|---|
| Person / Institution _____ | Person / Institution _____ |
| Address _____ | Address _____ |
| City _____ | City _____ |
| State / ZIP _____ | State / ZIP _____ |
| Telephone # _____ | Telephone # _____ |
| *Pick Up Location:* ☐ Halsted Location ☐ Lincoln Avenue Location ☐ Glenview Location | |
| *Email Address (Vaccine Records Only)* * _____ | |

**I authorize the release of information covering the period(s) of healthcare from:**

Date(s) _____ To date(s) _____

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

☐Abstract (documents summarizing health history) ☐History and Physical Examination ☐Discharge Summary
☐Consultation Reports ☐Operative Reports ☐ Complete Record
☐Progress Notes ☐Vaccine Records (free of charge)
☐Diagnostic Reports ☐**Verbal only** (*please specify*)_____
☐Specialty (*please specify*)_____
☐ Other (*please specify*)_____

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

☐Genetic testing information and/or records ☐Information about child abuse and neglect

***PATIENT 12 or OVER MUST AUTHORIZE THIS RELEASE BY CHECKING THE BOX BELOW AND SIGNING:***

☐HIV/AIDS related health information and/or records
☐Behavioral or mental health information and/or records *(Release must be witnessed, Patient 12 or over must authorize)*
☐Information about sexually transmitted disease ☐Pregnancy ☐Birth control ☐Drug/alcohol diagnosis, treatment, and/or referral information

**Information will be used for the following purpose:**

| ☐***Not Transferring Out of Practice (please specify):*** | ☐***Transferring Out of Practice (please specify):*** |
|---|---|
| ☐My personal use **(there is a fee for personal use copies)** | ☐ Moving ☐ Aged-Out |
| ☐Sharing with other health care providers* | ☐ Insurance ☐ Dissatisfied |
| | ☐Sharing with other health care providers* |
| ☐Other *(please specify)* | |

****No charge if sent directly to the provider- address must be provided as recipient above***

**This authorization will expire:**

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

**By providing an email address, I agree to receive email communication that may contain protected health information. I understand that email transmissions cannot be guaranteed to be delivered, secured or error-free despite best efforts of sender. Sender does not accept liability for errors resulting from transmission.

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## Authorization for Release of Patient Health Information

Patient Name _____Patient Date of Birth _____

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above. *For mental health purposes this authorization will expire one year form 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 to the recipient identified in the Authorization, in which case Ann & Robert H. Lurie Children's Hospital of Chicago may refuse to treat me if I do not sign this Authorization.

I understand that once Lurie Children's discloses my health information to the recipient, Lurie Children's 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 the Lurie Children's Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that Lurie Children's 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 this disclosure specifically authorizes the re-disclosure.

I understand that I have the right to inspect and obtain a copy of any 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 Lurie Children's to use or disclose my health information in the manner described above.

_____ _____
**Printed Name of Patient or Legal Guardian** **Relationship**

_____ _____
**Signature of Patient or Legal Guardian** **Date**

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

*For Mental Health Releases Only:*

_____ _____
**Signature of Patient 12 or over** **Date**

_____ _____
**Witness** **Date**
*(Mental health releases must be witnessed)*

_____ _____
**Interpreter (as applicable)** **Date**

*For Office Staff Only:*

_____ _____
**Signature of Lurie Children's Staff** **Date**
(Lurie Children's Staff has checked the identification of the signer and ensured that this is the legal representative who has rights of access)