



**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**  
**MUST COMPLETE ALL BLANK LINES**

<b>PATIENT INFORMATION</b>	Patient Name: Address: City, State, Zip Code: Phone Number: _____ Date of Birth: _____
<b>PROVIDER/ORGANIZATION:</b> (Who is authorized to release your information)	<b>I hereby authorize:</b>
<b>REQUESTOR:</b> (To whom you want your information to go)	<b>To Release my medical records to:</b> Name: Address: City, State, Zip Code: Phone Number: _____
<b>PURPOSE</b>	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other
<b>INFORMATION TO BE DISCLOSED:</b>	<input type="checkbox"/> Abstract <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Results <input type="checkbox"/> Other (please be specific): _____ Date(s) of Visit: _____
<b><u>HIGHLY CONFIDENTIAL INFORMATION</u></b> I <input type="checkbox"/> do <input type="checkbox"/> do not want HIV/AIDS information released under this authorization. I <input type="checkbox"/> do <input type="checkbox"/> do not want drug/alcohol abuse or treatment information released under this authorization. I <input type="checkbox"/> do <input type="checkbox"/> do not want genetic testing information released under this authorization. I <input type="checkbox"/> do <input type="checkbox"/> do not want sexually transmitted disease information released under this authorization. I <input type="checkbox"/> do <input type="checkbox"/> do not want mental health information released under this authorization. If age 12-17 must be signed by the child below.	

By signing below,

- I understand that this authorization is **voluntary** and I can refuse to sign this authorization. I understand that person(s) or organization(s) may **NOT** condition my **treatment, payment or enrollment** based on my signature on this authorization.
- I understand any disclosure of information carries with it the **potential for an unauthorized re-disclosure** and once the information is re-disclosed it **may not be protected** by the HIPAA privacy rule.
- I understand I have **the right to revoke** this authorization at any time. If I revoke this authorization I must do so in writing to the Health Information Department of the OSF Healthcare Facility listed above under Provider/Organization. I understand that the revocation will not apply to information that has already been disclosed in response to this release.
- I understand I have the right to inspect the information to be disclosed.
- I understand this authorization will **expire 1 year from the date of the signature** below or **upon a date, event or condition that I am specifying here:**

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Child (12-17) for MHDDCA purposes only*  
 405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signed by Patient Representative, state relationship to Patient and provide evidence of Authority to act for individual*

\_\_\_\_\_  
*Signature of witness who can verify patient identity*