Howard Brown Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____ Date of Birth:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email (optional):_____

I hereby authorize and request that: Howard Brown Health, Medical Records Department
4025 N. Sheridan Rd., Chicago, IL 60613
773-388-8936 (fax) / 773-388-8667 (phone)

- **Disclose information to me_____**
- **Disclose information TO_____ receive information FROM_____ exchange information with_____:**

_____

_____

City:_____ State:_____Zip:_____

Phone:_____ Fax:_____

Conditions or limits on disclosure (optional):_____

I request the release of the following information (INITIAL ALL THAT APPLY):*

_____COMPLETE HEALTH RECORD	_____X-rays	_____Lab Tests/Reports
_____Discharge Summary	_____Radiology	_____Case Management Notes/Reports
_____History and Physical Exams	_____EKG/EEG	_____ COVID test results/employer letters
_____Physician/Consultation Reports	_____Progress Notes	_____ Other:_____

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

_____Mental/Behavioral Health	_____Sexually Transmitted Diseases
_____Developmental Disability	_____HIV/AIDS
_____Alcohol/Substance Abuse	_____DNA Testing/Genetic Disorders
_____Domestic Violence/Sexual Assault	_____ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

Purpose of disclosure:_____ Date/range of requested information (if applicable):_____

FOR TEXT, VOICEMAIL/ANSWERING MACHINE, OR EMAIL DELIVERY OF INFORMATION (to patient only):

I understand that text, voicemail, or email delivery may not be secure, and that Howard Brown Health cannot guarantee the privacy or security of my phone number, email address, or related device(s). I understand this risk and consent to and authorize the delivery of the information requested above to me, as follows (check all that apply):

____ by text message at the telephone number indicated above
____ by leaving a voicemail or voice message at the telephone number indicated above
____ by sending an email to the email address indicated above

This Authorization is valid for one year or until (select date no more than 12 months from signature):_____

I UNDERSTAND THAT THIS AUTHORIZATON IS VOLUNTARY, AND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ADDRESS ABOVE. ANY REVOCATION DOES NOT APPLY TO RECORDS ALREADY RELEASED IN GOOD FAITH PURSUANT TO THE ABOVE RELEASE. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION BEING DISCLOSED PURSUANT TO THIS AUTHORIZATION. I UNDERSTAND THAT A MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION, BUT IT HAS BEEN EXPLAINED TO ME THAT IF I DECLINE TO CONSENT TO THIS RELEASE OF INFORMATION, THE FOLLOWING CONSEQUENCES MAY APPLY, AS RELEVANT: MY PROVIDERS MAY BE UNABLE TO COORDINATE MY CARE; I MAY BE UNABLE TO APPLY FOR THIS PROGRAM; AND/OR THE REQUESTED RECORDS MAY NOT BE RELEASED. ANY COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____	_____	_____	_____
Signature of Person Authorizing Release	Date	Signature of Witness (Optional)	Date

NOTE: This Authorization must be completed and signed in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:_____

*** Requests for records may incur a charge, if and as allowed by law.**

Rev. 11/20/2020