



AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I hereby authorize and request that:

Howard Brown Health
Medical Records Department
4025 N. Sheridan Road
Chicago, IL 60613
773-388-8936 fax / 773-388-8667 phone

provide information **TO** _____ receive information **FROM** _____ exchange information with _____:

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

for the purpose of: _____

Date or range of dates of requested information: _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> COMPLETE HEALTH RECORD | <input type="checkbox"/> X-rays | <input type="checkbox"/> Lab Tests/Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology | <input type="checkbox"/> Case Management Notes/Reports |
| <input type="checkbox"/> History and Physical Exams | <input type="checkbox"/> EKG/EEG | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Physician/Consultation Reports | <input type="checkbox"/> Progress Notes | _____ |

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):

- | | |
|---|--|
| <input type="checkbox"/> Mental/Behavioral Health | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> DNA Testing/Genetic Disorders |
| <input type="checkbox"/> Domestic Violence/Sexual Assault | <input type="checkbox"/> ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS |

This Authorization is valid until (SELECT DATE NO MORE THAN 12 MONTHS FROM SIGNATURE): _____

I UNDERSTAND THAT THIS AUTHORIZATION 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 (Encouraged but not Required)

Date

NOTE: This Authorization must be completed in its entirety 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: _____