Howard Brown Health

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):

_____COMPLETE HEALTH RECORD	_____X-rays	_____Lab Tests/Reports
_____Discharge Summary	_____Radiology	_____Case Management Notes/Reports
_____History and Physical Exams	_____EKG/EEG	_____Other (specify):_____
_____Physician/Consultation Reports	_____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):

_____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

This Authorization is valid 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 (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:_____

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

Rev. 7/2019