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 Rd., Chicago, IL 60613*
*773-388-8936 fax / 773-388-8667 phone*

**disclose information *TO*** ____ **receive information *FROM*** ____ **exchange information with** ____:

_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

**Purpose of disclosure**:_____ **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 |

**If requesting email delivery, you must initial and complete the following:** _____(initial) I hereby authorize that any of the information requested above may be delivered via secure, encrypted email to the following email address:_____

**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. 11/2019