



**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  
6500 N. Clark St., Chicago, IL 60626  
(773) 388-8936 (fax) | (773) 388-8796 (care coordination fax) | (872) 268-5900 (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 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 (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:** \_\_\_\_\_