8100 W. 119th Street
Palos Park, Il 60464
708-361-3300
708-361-8139 Fax

9400 Bormet Drive
Mokena, Il 60448
708-479-7337
708-361-8139 Fax

AUTHORIZATION FOR RELEASE OF PATEINT HEALTH INFORMATION

Patient Name: ____

Address: ____Apt #: _________

City: ____State: _____________ Zip: ___________

Date of Birth: ____________________ Phone Number: _____________________________________

Do you give permission to leave a message at this number? ☐ Yes or ☐ No

I hereby authorize that the protected health information regarding the above-named person be forwarded:

To: Person/ Institution____

Address____

City____State__________Zip Code__________

From: Person/institution____

Address____

City_______________________________________State_____________Zip Code__________

Purpose of need for information:____

(e.g. Insurance, Moving, Continuation of Care, Personal, Disability, School, Employer, Legal

I understand that the information to be disclosed may include information regarding genetic testing, mental health/developmental disabilities, Substance Use Disorder, HIV test results, and AIDS/AIDS related illness. We will release this information, unless you indicate which information should be excluded below.

☐ Substance Use Disorder ☐ HIV test results ☐ Mental Health/Developmental Disabilities

☐ Genetic testing ☐ AIDS/AIDS Related illness ☐ Sexually Transmitted Disease

DATES OF SERVICE TO BE RELEASED From:_______/________/________ **To:**______/_______/_________

Turn over to complete form

If I can't personally pick up medical records, you may release the copies to:___________________________

I understand the following:

1.) I understand that there is a charge of $25.00 for copying these medical records and I am responsible for any outstanding balances.

2.) That this authorization is voluntary and I can refuse to sign this form.

3.) That this authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care. I understand that once the authorized information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulation.

4.) That this authorization will expire 1 year from the date it was signed.

5.) I understand that I have a right to inspect and receive a copy of the health information I have authorized to be disclosed. If I do not sign this Authorization, the institution named will not release my health information.

6.) That the person/institution will not refuse to treat me based on whether I agree to allow health information to be used and disclosed to others.

7.) The information to be disclosed may include information related to behavioral and mental health services, developmental disabilities, sexually transmitted disease, genetic testing, evaluation and treatment for alcohol or drug abuse, results of HTLV-III, HIV or AIDS testing.

____ ____________________________

Signature of Patient | Date

____ ____________________________

Signature of Parent/Legal Guardian/Personal Representative | Relationship to Patient

____

Signature of Witness

REDISCLOSURE:
Notice is herby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.

Revised 09/16/2022