



Authorization to Disclose/Release Protected Health Information

(Must be signed by patient or legal representative before medical records will be released and must be completed in its ENTIRETY)

Patient Name: _____ **Date of Birth:** _____ **Phone:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

I authorize Illinois Bone and Joint Institute to use/disclose a copy of the specified protected health information as indicated below to (Recipient):

Recipient: Name _____ **Phone:** _____ **Fax:** _____

Address/Email: _____ **City:** _____ **State:** _____ **Zip Code:** _____

I understand that if this information is emailed per my request, there may be some level of risk that this information could be read by an unauthorized third party.

Send the entire medical record (all information) to the above-named recipient.

Send only the following information to the above-named recipient: _____

Records for the period (dates) from: _____ to _____

Purpose or need for information: Continuation of care Personal use Other/Describe:

I understand that my medical record may include information relating to treatment for mental health, STDs, AIDS, HIV, or alcohol and/or substance abuse, and genetic testing results. If I do not wish such information to be released, check which of the information you wish to be excluded below*.

- HIV/AIDS/STD related information/records
- Genetic testing information/records
- Mental health information/records
- Drug/alcohol diagnosis, treatment or referral

- I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that this authorization is voluntary and my ability to obtain treatment or payment or my eligibility for benefits will not be a condition to signing this authorization. I may inspect or receive a copy of any information used/disclosed under this authorization.
- I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. I understand that this authorization will expire on the following specific date, event, or condition related to the purpose of this disclosure.

Unless otherwise specified, this form expires one year from date of signature.

Signature of Patient or Patient’s Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____

*Witness Signature is required for release of mental health, genetic testing, HIV, and substance abuse records.

Print Name of Witness: _____ Date: _____

Signature of Witness: _____ Date: _____