

Health Information Management
833 S. Wood Street, Room B-52
Chicago, IL 60612
Phone: 312-996-6830
Fax: 312-413-8014



**University of
Illinois**
Medical Center

at Chicago

Health Information Management
833 S. Wood Street M/C 772
Chicago, IL 60612

Other UIMCC location (please specify):

AUTHORIZATION TO RELEASE HEALTH INFORMATION

****There may be a fee for copies****

Patient Name _____ MR# _____

Date of Birth _____ / _____ / _____ Telephone (_____) _____

I hereby authorize the University of Illinois to:

RELEASE TO:

OBTAIN FROM:

Person/Facility Agency _____

Address _____

City, State, Zip _____

Specific description of information that may be used / disclosed:

INPATIENT Dates of Treatment _____

(abstract will be provided unless specified otherwise)

OUTPATIENT Dates of Treatment _____

EMERGENCY ROOM Dates of Treatment _____

RADIOLOGY Dates of Treatment _____ CD Films Reports

Other (please specify) _____

The information will be used / disclosed for the following purpose:

Continuing Care Personal Use Legal Other (please specify)

I authorize the University of Illinois to release sensitive information as indicated:

The patient 12 or over who consented to the treatment must authorize the release of sensitive information.

AIDS / HIV Drug / Alcohol Abuse Behavioral Health Genetic Information

Sexual Assault Child Abuse Developmental Disabilities

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

I understand that I may revoke this authorization at any time by notifying the person / organization providing the information in writing. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

If not otherwise specified, this authorization will expire within 90 days of the date of signature.

Patient Signature

Date

Legal Representative Signature

Relationship to Patient

Witness Signature

Relationship to Patient



0 4 0 4 E A

UI - 0404EA (01/09)