



**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**  
**MUST COMPLETE ALL BLANK LINES**

<b>PATIENT INFORMATION</b>	Patient Name: _____ Address: _____ City, State, Zip Code: _____ Phone Number: _(_____)_____ Date of Birth: _____
<b>PROVIDER/ORGANIZATION:</b> (Who is authorized to release your information)	<b>I hereby authorize:</b> Name: _____ Address: _____ City, State, Zip Code: _____ Phone Number: _(_____)_____
<b>REQUESTOR:</b> (To whom you want your information to go)	<b>To Release my medical records to:</b> Name: _____ Address: _____ City, State, Zip Code: _____ Phone Number: _(_____)_____ Fax Number: _____
<b>Disclose Records to</b>	<input type="checkbox"/> OSF MyChart <input type="checkbox"/> CD (mailed to address above) <input type="checkbox"/> Paper (mailed to address above) <input type="checkbox"/> Encrypted Email _____ <input type="checkbox"/> Fax _____
<b>PURPOSE</b>	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other _____
<b>INFORMATION TO BE DISCLOSED:</b>	<input type="checkbox"/> Abstract <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Results <input type="checkbox"/> Imaging Films <input type="checkbox"/> Medical Bills <input type="checkbox"/> Other (please be specific): _____ Date(s) of Visit: _____
<b><u>HIGHLY CONFIDENTIAL INFORMATION</u></b> <i>It is my full understanding that the records and communications to be disclosed <b>WILL</b> include all Highly confidential information such as alcohol and substance abuse, mental health, developmental disabilities, HIV/AIDS, and genetic testing and information derived from genetic testing information. If you want to have any of this information excluded, check below.</i>	
<input type="checkbox"/> Alcohol/Substance Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Genetic Testing and information derived from genetic testing <input type="checkbox"/> Other: _____	

**By signing below,**

- I understand that this authorization is **voluntary**, and I can refuse to sign this authorization. I understand that person(s) or organization(s) may **NOT** condition my **treatment, payment or enrollment** based on my signature on this authorization.
- I understand any disclosure of information carries with it the **potential for an unauthorized re-disclosure** and once the information is re-disclosed it **may not be protected** by the HIPAA privacy rule.
- I understand I have **the right to revoke** this authorization at any time. If I revoke this authorization I must do so in writing to the Health Information Department of the OSF Healthcare Facility listed above under Provider/Organization. I understand that the revocation will not apply to information that has already been disclosed in response to this release.
- I understand I have the right to inspect and copy the information to be disclosed.
- I understand this authorization will **expire 1 year from the date of the signature** below or **upon a date, event or condition that I am specifying here:** \_\_\_\_\_

\_\_\_\_\_  
*Signature of Patient or Patient Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Child (12-17) for MHDDCA purposes only (Illinois)*  
*405 ILCS 5 Mental Health and Developmental Disabilities Confidentiality Act*  
*Signature of Child (14-17) for MHDDCA purposes (Michigan)*  
*Michigan Mental Health Code Confidentiality (MCL330.1740-1750)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signed by Patient Representative, state relationship to patient and provide evidence of Authority to act for individual*