

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

MUST COMPLETE ALL BLANK LINES

PATIENT INFORMATION	
	Patient Name:
	Address:
	City, State, Zip Code:
	Phone Number: _() Date of Birth:
PROVIDER/ORGANIZATION:	I hereby authorize:
(Who is authorized to release	Name:
your information)	Address:City, State, Zip Code:
	Phone Number: _()
REQUESTOR:	To Release my medical records to:
(To whom you want your	Name:
information to go)	Address:City, State, Zip Code:
	Phone Number: _(Fax Number:
Disclose Records to	☐ OSF MyChart ☐ CD (mailed to address above) ☐ Paper (mailed to address above)
	☐ Encrypted Email
PURPOSE	Continuing Care Insurance Legal Personal Other
INFORMATION TO BE	Abstract Entire Medical Record Lab Results Radiology Results Imaging Films Medical Bills
DISCLOSED:	Other (please be specific):
	Date(s) of Visit:
HIV/AIDS, drug and alcohol abu of this information excluded, ch	the records and communications to be disclosed <u>WILL</u> include Highly confidential information such as se, sexually transmitted disease, genetic testing, and mental health information. If you want to have any neck below. Mental Health Developmental Disabilities HIV/AIDS Genetic Testing
By signing below, I understand that this author condition my treatment, pay I understand any disclosure it may not be protected by I understand I have the rigit Department of the OSF Heat that has already been disclosure.	rization is voluntary , and I can refuse to sign this authorization. I understand that person(s) or organization(s) may NOT yment or enrollment based on my signature on this authorization. e of information carries with it the potential for an unauthorized re-disclosure and once the information is re-disclosed
	on will expire 1 year from the date of the signature below or upon a date, event or condition that I am specifying
orginature of Faulent OF Faulent Nepresel	native Date
Signature of Child (12-17) for MHDDCA 405 ILCS 5 Mental Health and Developm	