Authorization to Release Protected Health Information

Shirley Ryan AbilityLab®

PLEASE PRINT:

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

DATE OF BIRTH (MM/DD/YYYY) _____ PHONE _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

RELEASE INFORMATION FROM:

☐ **Shirley Ryan AbilityLab,** 355 East Erie Street, Chicago, IL 60611

☐ Other

Name _____

Address _____

_____

Phone _____

Fax _____

RELEASE INFORMATION TO:

☐ **Shirley Ryan AbilityLab,** 355 East Erie Street, Chicago, IL 60611

In care of: _____

☐ Same person and address noted at the top of this form

☐ Other

Name _____

Address _____

_____

Phone _____

Fax _____

DELIVERY

Paper copies of the requested information will be **mailed** to the address above, unless one or more of the following options are selected:

☐ Provide on CD

☐ Pick-up

☐ Secure E-mail (PRINT): _____

SERVICE DATES

FROM: _____

TO: _____

INFORMATION TO BE RELEASED *(check all that apply)*

☐ Abstract *(History and Physical, Discharge Summary, Consultation Reports, Test Results, Therapy Notes)*

☐ Billing Information

☐ Progress Notes

☐ Diagnostic/Radiology

☐ Lab Results

☐ Operative Procedure/Pathology Reports

☐ Other _____

PURPOSE OF RELEASE

☐ Disability Determination

☐ Insurance

☐ Legal Purposes

☐ Other _____

☐ Personal

☐ Treatment/Continued Care

The following information will be released <u>ONLY IF</u> you check an item(s) below and include a witness signature at bottom of form:

☐ Psychiatric/mental health and/or developmental disabilities information. *If the patient is 12–17 years old, they must also sign here to approve release:*

_____

☐ Testing results, diagnosis, or treatment of HIV/AIDS-related illness

☐ Pain Management

☐ Vocational Rehab

☐ Chaplaincy Notes

I can revoke (take back) this Authorization at any time in writing to the Shirley Ryan AbilityLab Director of Medical Records, except to the extent that action has already been taken to release this information. This Authorization will remain valid unless revoked, but will expire one year after the date below. I can inspect a copy of my health information to be released. If I do not sign this Authorization, the Shirley Ryan AbilityLab will not release my health information, except in instances defined in its Notice of Privacy Practices or otherwise permitted by law. The Shirley Ryan AbilityLab will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that there may be copying and/or processing fees associated with this release, such pricing to be disclosed to me upon my request. The health information disclosed under this Authorization may be re-disclosed by the recipient to others. However, federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **DATE**

_____ _____

RELATIONSHIP OF AUTHORIZED REPRESENTATIVE TO PATIENT *(Please provide a copy of the authorization when submitting this form.)* **WITNESS SIGNATURE**