AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: **Phone #:**

Date of Birth: **PCP:**

I hereby authorize: Erie Family Health Centers, Health Information Department, 2750 W North Avenue, Chicago, IL 60647
Telephone: 312-432-2055 Fax: 312-432-4372 Email: ROI@eriefamilyhealth.org

( ) to Release to: _____
(Name of Health Care Facility, Individual or Agency)

( ) to Receive from:

_____
(Address)

_____
(City, State, Zip)

_____
(Phone/ Fax)

PURPOSE OR NEED FOR DISCLOSURES: (Check Applicable Categories)

( ) Personal Use ( ) Disability Determination ( ) Transfer or Continuing Care (Last 2 years of Info)
( ) Legal Counsel ( ) Insurance/ Benefits ( ) Upcoming Appt Date: _____

( ) Other (specify): _____

FORMAT FOR RECORDS: ( ) Paper copy
Please refer to Pay Scale for rates
( ) Encrypted Email (email address): _____

DELIVERY METHOD: ( ) Pick up at Erie Facility: _____
Copy of ID Required ( ) Fax ( ) U.S. Postal Mail

HEALTH INFORMATION REQUESTED:

( ) Office Visit Notes ( ) Immunization/ Shot Records ( )School Physical Forms ( ) Lab Reports ( ) Billing Records

( ) Complete Chart ( ) Prenatal Records ( ) Radiology/Imaging Reports ( ) Other: _____

DATES REQUESTED: ( ) MOST RECENT ( ) FOR THE FOLLOWING DATE(S): From ___/___/___ to ___/___/___

Federal and State Laws require special permission to release certain information. Please check if these records should be released: ( ) Mental/ Behavioral Health ( ) Alcohol/ Substance Use ( ) HIV/AIDS Testing Results or Information

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time by submitting a written revocation to the Medical Records Department (except to the extent that action based on it has already been taken.) In the event that written revocation is not made, this authorization will automatically expire in six months or on the following date or event: _____.

_____ _____
Signature: Patient or Legally Authorized Patient Representative Date

_____
If signed by other than patient, state relationship

_____ _____
Signature of Witness Date

*For the release of Mental Health Information of patients between ages 12-17, patients from 12-17 years of age are required to sign authorization in addition to their parent or guardian.

Notice to Receiving Agency/Person: This information has been disclosed to you from Protected Health Information whose privacy is protected by Federal Laws. This information may no longer be protected once it is used or disclosed in accordance with the authorization. Under the provisions of the Mental Health and Developmental Disabilities Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July 1, 1993 Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor such information for such records may be further disclosed without specific authorization for such re-disclosure. Under the Illinois Aids Confidentiality Act, no person to whom the test results have been disclosed may disclose the test results to another person except as authorized pursuant to treatment, payment, enrollment; or eligibility for benefits based on authorization of this information. PHI Authorization Form