American Indian Health Service of Chicago, Inc.
Authorization for Use or Disclosure of Health Information

Please complete all sections, date, and sign

I, _____DOB: _____
Patients Name (Last) (First) (Middle Init)

_____
Address (City) (State) (Zip)

Other names medical record maybe located under: _____
(Last) (First) (Middle Init)

Guardian name if signing for client: _____
(Last) (First) (Middle Init)

The information / communication is to be disclosed by (name, address, phone number of facility):

_____

_____

To be provided to/communicate with (name, address, phone number of facility):

_____

_____

FOR THE PURPOSES OF PROVIDING THE FOLLOWING SERVICES FOR ME:
[ ] Self [ ] Insurance [ ] Workers Comp [ ] Disability [ ] Attorney [ ] Changing Physicians
[ ] Consultation [ ] Primary Care [ ] Other_____

THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: (CHECK APPROPRIATE BOX(ES)
[ ] All Medical Records [ ] All Dental Records [ ] Radiology Reports [ ] Immunization Record
[ ] Clinic visit notes last__years [ ] laboratory Results [ ] Consultation Reports
[ ] Admit H&Ps, DC Summaries, ER Reports [ ] other (specify) _____

Only information related to (specify):_____

Only the period of events from: _____ to _____

[ ] Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist – patient privilege)

Check and initial the applicable item(s) below to authorize the following sensitive information to be disclosed.
[ ] Substance Abuse which includes (Alcohol –Drug Abuse) [ ] Abuse Treatment/Referral [ ] HIV/AIDS Tests/Treatment
[ ] Sexually Transmitted Disease [ ] Mental Health (other than psychotherapy notes.

This consent will expire: _____

This authorization maybe revoked by me in writing at any time except to the extent that action has already taken. I am aware the information from my medical record is confidential and protected by federal and state law. Federal and state regulations (42CFRand RCW 71.05.390) prohibit you from making any further disclosure of these medical records without my specific consent, or as otherwise permitted by such regulations. Unless cancelled earlier by me, this authorization will expire ninety (90) days from signature date, or specified expiration date.

Patient's Signature: _____ Date: _____

_____Date: _____
Signature of Authorized Representative (state relationship to patient)
Or Witness (If signature is by thumb print or mark)