AMERICAN INDIAN HEALTH SERVICE OF CHICAGO, INC

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please complete all sections, date and sign.

NAME: _____ DOB: _____

I hereby voluntarily authorize the disclosure of Information from my health record.

Other names medical record may be located under: _____

The information / communication is to be disclosed by:

Name of facility: _____ Phone: _____

Address of facility: _____

To be provided to / communication with:

Name of facility/person: _____ Phone: _____

Address of facility: _____

FOR THE PURPOSE OF PROVIDING THE FOLLOWING SERVICES FOR ME:

◯ Further medical care ◯ Personal use ◯ Insurance ◯ Attorney Other_____

The information to be disclosed from my health record: (check appropriate box(es))

◯ All Medical Records ◯ All Dental Records ◯ Radiology Reports ◯ Immunizations
◯ Clinic Visit Notes last ___years ◯ Lab Reports _____ ◯ Consultation Reports
◯ Admit H&Ps, DC Summaries, ER Reports ◯ Other (specify) _____
Only information related to (specify): _____
____ Only the period of events from: _____ to _____

CHECK AND INITIAL the applicable item(s) below to authorize the following sensitive information to be disclosed.
____ ◯ Alcohol/Drug ____ ◯ Abuse Treatment/Referral ____ ◯ HIV/AIDS Tests/Treatment
____ ◯ Sexually Transmitted Infections ____ ◯ Mental Health/ Behavior Health notes

I understand that I may revoke this authorization in writing submitted at any time to the health Information management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from date of my signature unless a different expirations date or expirations event is stated. **This consent will expire:** _____.

I understand that AIHSC will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) Research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CRF Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Portability and Accountability Act Privacy Rule (45 CRF Part 164) and the Privacy Act of 1974 {5 USC 552a}

Patient's Signature: _____ Date: _____

_____ Date: _____

Signature of Authorized Representative (state relationship to patient) or Witness (if signature is by thumb print or mark)