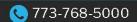
HEALTH INFORMATION REQUEST





identified above is voluntary and I need not sign this form to ensure healthcare treatment.



高 773-978-8367 🔀 ROl@chicagofamilyhealth.org



PATIENT INFORMATION		Medical Record No		
Name:			Birthdate:	//
Address:			Phone:	
AUTHORIZATION FOR DISCLOSURE OF HEAD I hereby authorize protected health info		ve-named person be fo	warded as foll	ows:
FROM: Person / Institution				
Address:				
City: State: .	Zi	p:	<u> </u>	
TO: Person/Institution				
City: State: _				
Delivery Method: Pick up in perso	on U.S. Mail	Fax to:		Other
Reason for request:				
Face SheetHistory & PhysicaX-rEKG/EEG ReportConsultation Records FROM: THE RELEASE OF INFORMATION ON CERTA Without authorization, the following information to the following (initial all that apply). Mental/Behavioral Health Sexually Transmitted Infection (STI) Alcohol/substance abuse Developmental disability HIV/AIDS	ay/radiology ReportPan Report Discharge Su TO: AIN CONDITIONS / TREATMENT formation will not be released DNA testing/genetic components of the above listed treatments	athology Report Erummary Other ITS REQUIRES MY SPECIF ed. I authorize the releading in the second itions or	ric authorization of a National The minor's signal release informations.	FION. on relating MINOR (ages 12-17): ture is required to on regarding care for DS/HIV/STD, drug or
This authorization is valid until// I understand that I have the right to revoke this author that if I revoke this authorization, I must do so in writin to the health information management department. I understand that the revocation will not apply to my in provides my insurer with the right to contest a claim unexpiration date, event, or condition, this authorization which it was signed. I understand that once the above redisclosed by the recipient and the information may relaws or regulations. I understand authorizing the use of identified above is valuntary and I need not sign this fet.	ization at any time. I understand and present my written revocation understand that the revocation will ad in response to this authorization. Insurance company when the law under my policy. If I fail to specify an will expire 1 year from the date on information is disclosed, it may be not be protected by federal privacy of disclosure of the information	Patient signature Parent/Legal Guardian/ Witness Primary Care Provider (Date: