HEALTH INFORMATION REQUEST

773-768-5000 773-978-8367 ROI@chicagofamilyhealth.org

CFHC CHICAGO FAMILY HEALTH CENTER

PATIENT INFORMATION

Medical Record No. _____

Name: _____ Birthdate: ___/___/____

Address: _____ Phone: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize protected health information regarding the above-named person be forwarded as follows:

FROM: Person / Institution _____

Address: _____

City: _____ State: _____ Zip: _____

TO: Person / Institution _____

Address: _____

City: _____ State: _____ Zip: _____

Delivery Method: ☐ Pick up in person ☐ U.S. Mail ☐ Fax to: _____ ☐ Other

Reason for request: _____

DISCLOSURE WILL INCLUDE: (CHECK ALL THAT APPLY)

___Face Sheet ___History & Physical ___Lab Report ___Operative Report ___Itemized Bill ___Nurse Notes

___Progress/Physician notes ___X-ray/radiology Report ___Pathology Report ___Emergency Report

___EKG/EEG Report ___Consultation Report ___Discharge Summary ___Other

Records FROM: _____ TO: _____

THE RELEASE OF INFORMATION ON CERTAIN CONDITIONS / TREATMENTS REQUIRES MY SPECIFIC AUTHORIZATION.
Without authorization, the following information will not be released. I authorize the release of information relating to the following (initial all that apply).

Mental/Behavioral Health ___
Sexually Transmitted Infection (STI) ___
Alcohol/substance abuse ___
Developmental disability ___
HIV/AIDS ___
DNA testing/genetic disorders ___
Domestic Violence/Sexual assault ___
All of the above listed conditions or treatments ___

CONSENT OF A MINOR (ages 12-17):
The minor's signature is required to release information regarding care for mental health, AIDS/HIV/STD, drug or alcohol abuse, or family planning.

This authorization is valid until ___/___/___ *(Select date no more than 12 months from signature)*

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date on which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use of disclosure of the information identified above is voluntary and I need not sign this form to ensure healthcare treatment.

Date:

_____ ___/___/___
Patient signature

_____ ___/___/___
Parent/Legal Guardian/Representative

_____ ___/___/___
Witness

_____ ___/___/___
Primary Care Provider (PRINT)