1634 West Polk Street Chicago, Illinois 60612 (312) 423-4200 www.unionhealth.org

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

I Hereby Authorize the Following Release:

From:____
Facility Name Address City /State Zip Code

Dr.'s. Name:______________________________ Telephone# (_____)__________________

To:____
Facility Name Address City/State Zip Code

Dr.'s. Name:______________________________ Telephone # (_____)__________________

____
Patient Name Address

____
City State Zip Code (Area Code) Telephone #

____
Gender Birthdate Medical Record Number

The purpose of this request is:____

Information to be obtained or released (circle one) – (check all documents that apply below).

______Entire Medical Record ______Last 2 Years Activity

______Emergency Room Record ______Billing Statements

______History & Physical Examination ______Progress Notes

______Consultation Report ______Laboratory Results

______X-Ray Report______Mammography______Ultrasound______Cat Scan_____MRI

______Other, please specify ____

I understand that this disclosure may include information relating to: (initial below if applicable).

________Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

________Behavioral Health services/Psychiatric care

________Treatment for Alcohol and /or Drug abuse

________Genetic Testing or Infertility (Circle One)

________Other, please specify ____

(Continued on Back Sheet)

(Cont'd.) AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

I understand and acknowledge the following:

1). That my health information is protected by law under Federal Privacy Regulations; Public Law 104-191, Health Insurance Portability & Accountability Act (HIPAA). UHS will not condition treatment, payment or enrollment in the health plan, or eligibility for benefits on the patient providing authorization for the requested use or disclosure.

2). That the information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), infection: (2) treatment for Drug or Alcohol abuse; or (3) Mental or Behavioral Health or Psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, they are not subject to release, except as required by law, or as ordered by a judge.

3). That if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be redisclosed and no longer protected by the Health Insurance Portability & Accountability Act, (HIPAA). However, the recipient may be prohibited from disclosing substance abuse and or alcohol treatment.

4). That the facility I am authorizing to use and/or disclose this information may receive compensation for doing so, to cover the costs of retrieving and reproducing this information.

5). I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits. I may request to inspect or obtain a copy of any information to be used and/or disclosed under this authorization.

6). That this authorization may be revoked at any time, except to the extent that action has already been taken in good faith by this authorization. Unless otherwise revoked, this authorization will automatically expire 90 days from the date of my signature.

7). I hereby release UNION HEALTH SERVICE, INC., employees and physicians from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

Signed:____

(Patient) (Date)

____

(Signature of Parent, Next of Kin, or Legal Representative, as required (Relationship to Patient) (Date)

____

(Signature of Witness) (Relationship to Patient) (Date)

Rev. 1/16/04