ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

Authorization to Disclose/Release Protected Health Information

(Must be signed by patient or legal representative before medical records will be released and must be completed in its ENTIRETY)

Patient Name: _____ **Date of Birth**: _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

I authorize Illinois Bone and Joint Institute to use/disclose a copy of the specified protected health information as indicated below to (Recipient):

Recipient: Name:_____ Phone: _____ Fax: _____

Address/Email: _____ City: _____ State: _____ Zip Code:

I understand that if this information is emailed per my request, there may be some level of risk that this information could be read by an unauthorized third party.

☐ Send the entire medical record (all information) to the above named recipient.

☐ Send only the following information to the above named recipient: _____

_____

Records for the period (dates) from: _____ to _____

Purpose or need for information: ☐ Continuation of care ☐ Personal use ☐ Other/Describe: _____

I understand that my medical record may include information relating to treatment for mental health, STDs, AIDS, HIV, or alcohol and/or substance abuse, and genetic testing results. If you do not wish such information to be released, check which of the information you wish to be excluded below*.

☐☐HIV/AIDS/STD related information/records ☐ ☐ Genetic testing information/records

☐☐Mental health information/records ☐ ☐ Drug/alcohol diagnosis, treatment or referral

I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that this authorization is voluntary and and my ability to obtain treatment or payment or my eligibility for benefits will not be conditioned on signing this authorization. I may inspect or receive a copy of any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. I understand that this authorization will expire on the following specific date, event, or condition related to the purpose of this disclosure

_____.

Unless otherwise specified, this form expires one year from date of signature.

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____

*Witness Signature is required for release of mental health, genetic testing, HIV, and substance abuse records.

Print Name of Witness:_____ Date:_____

Signature of Witness:_____Date_____