AdvocateAuroraHealth

MRN _____

1) **PATIENT INFORMATION:**

_____ _____ _____ _____ _____
Name Address City State Zip

_____ (_____) _____
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

_____
Name of Health Care Provider/Plan/Other Address

3) **TO DISCLOSE TO:**

☐ Myself *(select delivery option below)*
- ☐ LiveWell/MyAdvocate Aurora portal ☐ View on Site
- ☐ Mail to my address above ☐ Pick up

If Mail or Pick up:
☐ Paper or ☐ Electronic format: _____

☐ If to be picked up by another, I hereby authorize _____ to pick up my records. *(Photo ID required.)*

☐ Send to third party: _____
Attn: _____
Address: _____
_____ *or*
Fax: _____
Third Party Phone #: _____

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL** (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ month/year) **If left blank, only information from the past two (2) years will be disclosed.**

6) **INFORMATION TO BE DISCLOSED:** ☐ All record types for time frame (unless excluded, see #7)

- ☐ **Hospital Summary** (See #6 on back side)
- ☐ **Consult**
- ☐ **Lab Reports**
- ☐ **Emergency Department**
- ☐ **Reports Visit/Progress Notes**
- ☐ **Imaging Results**
- ☐ **Imaging Films (x-ray)**
- ☐ **Procedure Op Reports**
- ☐ **Billing Records**
- ☐ **Estimate**
- ☐ **Other**_____

Behavioral Health
- ☐ **Treatment Records –** Treatment Plan & Notes, Assessment, Psychiatric/ Psychologic Eval, Labs, Medications
- ☐ **Psychologic Test Results**
- ☐ **Legal Status/Court Records**

7) I understand that the information to be disclosed may include information regarding genetic testing, mental illness/developmental disabilities, Substance Use Disorder, HIV Test results, and AIDS/AIDS related illness. We will release this information, unless you indicate which information should be excluded below.
- ☐ Substance Use Disorder ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities
- ☐ Genetic Testing ☐ AIDS/AIDS related illness

8) **EXPIRATION:** This Authorization is good for: *circle one* 1 month 6 months 1 year Other date or event _____
If this item is left blank, the authorization will expire in one year from the date signed. **IL Only:** Mental health/developmental disability records, information may be released only on the day the authorization is received.

9) **PURPOSE** (Check all that apply - **copy fees may apply)**
☐ Further Medical Care - **no fee** ☐ Insurance Eligibility/Benefits - **fee $**_____ ☐ Legal Investigation /Action – **fee $**_____
☐ Personal (at my request) - **possible fee $**_____ ☐ Forms Completion **- possible fee $** _____ ☐ Other: _____ *(specify)*

10) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** I understand that I do not need to sign this Authorization to receive treatment. I am aware that I may revoke this Authorization by notifying the health information department in writing. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization or needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____
11) **SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE** **DATE**
If signed by a person other than the patient, state your relationship to the patient:

_____

IL only – Witness signature for mental health/developmental disabilities records only: _____

AdvocateAuroraHealth

Authorization for Disclosure of Health Information Completion Instructions Complete all Sections of the Authorization Form

Add patient identifiers and contact information

1. Add patient identifiers and contact information
2. List the health care provider or other entity who will be releasing the information
3. Select the appropriate box that indicates if the patient will be receiving the information themselves (and the delivery option desired) or select the third-party checkbox to which the records should be sent, and the third party's delivery information.
4. Ignore Box 4 if the patient is receiving their own records. Check box #4 only if the patient is allowing back and forth exchange of their health information between the receiving entity in #3 with the releasing entity in #2.
5. List the date range of information that you want released. If left blank, only two years of Health Information will be released.
6. Select the appropriate box(es) to identify the specific information to be released or use the "Other" line to specify what is needed. A Hospital Summary is a general abstract that includes Discharge Summary, History & Physical, Consults, Operative Reports, Labs, Radiology Reports & Emergency Department Reports.
7. Substance Use Disorder treatment records, genetic testing, mental illness/development disabilities, HIV test results and AIDS/AIDs related illness information may be part of the records identified above. Use this section to identify if any of these record types should be excluded from the released information.
8. Add the expiration date of this authorization. Please note: In Illinois, if an expiration date is not listed, the authorization can only be honored on the date it is received by the releasing entity in #2 above.
9. Choose a Purpose (why these copies are needed) by selecting the appropriate check box. There may or may not be a fee for the copies, depending on the purpose selected.
10. Please read this section regarding patient rights with respect to this authorization.
11. Signature of the patient or the patient's legal representative and date of signature. If legal representative or someone other than the patient is signing, state your relationship to the patient.

IL Witness - Illinois patients, have a witness sign the form when mental health/developmental disabilities records are to be released.

A paper copy of this authorization form will be provided upon request.