Osteopathy Chicago, Ltd.

**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 Osteopathy Chicago, Ltd. 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 □ Litigation/Legal □Other/Describe: \_\_\_\_\_\_\_\_\_

Fees may be charged in accordance with Illinois State Statutes.

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 I 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 my ability to obtain treatment or payment or my eligibility for

benefits will not be a condition to 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_