CHICAGO DEPARTMENT OF PUBLIC HEALTH
AUTHORIZATION FOR RELEASE OF INFORMATION
RETURN COMPLETED FORM VIA SECURE FAX TO (312) 745-0397
QUESTIONS MAY BE DIRECTED TO (312) 747-9782 OR (312) 747-9672

Client Name_____D.O.B.___/___/___ID#_____

I, _____authorize
(Patient /parent of child < 18 years)

_____
(Facility/Person) (Address)

to release records and information relating to my (or my child's) health care and any services I (or my child) have received to:

_____
(Agency Person)

_____
(Address)

_____ _____
(Telephone) (Fax, if applicable)

The information to be disclosed shall include:

- ☐ Lab reports
- ☐ Diagnostic evaluations
- ☐ Radiology Report
- ☐ X-Rays/films
- ☐ Billing history
- ☐ Pathology Report
- ☐ Counseling notes
- ☐ Discharge Summary
- ☐ Entire Medical Record
- ☐ Immunizations
- ☐ Records for the following dates of treatment: _____

Other instructions:_____

I understand that if I so indicate below, this information may include the following:

- ☐ STD Test Results & Treatment
- ☐ HIV/AIDS Test Results and Treatment
- ☐ Mental Health Treatment
- ☐ Drug Treatment/Evaluation
- ☐ Alcohol Treatment
- ☐ Domestic Violence History

These records shall be used for the purpose of: _____

This authorization is valid until_____
I understand that: I have the right to revoke this authorization in writing at any time. · Revoking this authorization shall have no effect on disclosures made before the withdrawal of the authorization. · The Chicago Department of Public Health may not condition treatment or eligibility for benefits on this authorization or my refusal to sign such authorization. The information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.

_____
Signature of Patient/Parent of child < 18 years (Date)

_____
Signature of Personal Representative (if applicable) (Date)

_____
Personal Representative relationship to individual (*i.e.,* authority to act on individual's behalf)