AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:			
D.O.B.:		Medical ID# (if known):	

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:

- ☐ Counseling Notes
- ☐ Billing History
- ☐ Diagnostic Evaluations
- ☐ Discharge Summaries
- ☐ Entire Medical Record
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ X-Rays/Films
- ☐ 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
- ☐ Alcohol Treatment
- ☐ Mental Health Treatment
- ☐ Drug Treatment/Evaluation
- ☐ Domestic Violence History

These records shall be used for the purpose of:

Submit questions or requests by:
Mail: Chicago Department of Public Health, Attn: Compliance; 111 W. Washington St., Fourth Floor, Chicago, IL 60602
Email: cdphcompliance@cityofchicago.org

This Authorization is valid until: *(Date)* _____

I understand that: (1) I have the right to revoke this Authorization in writing at any time to the address listed below (2) Revoking this Authorization shall have no effect on disclosures made before the withdrawal of the Authorization (3) The Chicago Department of Public Health may not condition treatment or eligibility for benefits on this Authorization or my refusal to sign such Authorization (4) The information disclosed pursuant to this 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's Relationship to Patient*

FOR OFFICIAL USE ONLY

Received By:	
Date:	

Processed By:	
Date:	