La Rabida Children's Hospital Authorization for Release of Protected Health Information

Section I: PATIENT INFORMATION

Patient Name:	Date of Birth:
Address:	
City/State/Zip Code:	
Phone:	Medical Record #:
Email:	

Section II: INFORMATION REQUESTED

I authorize La Rabida Children's Hospital to use or disclose the following protected health information during the term of this authorization *(check all that apply)*:

Specific Information Requested:

☐ Abstract (Documents summarizing health history)	☐ Discharge Summary	☐ Therapy Notes (PT, OT, Speech)
☐ Acute Care Clinic/ER Record	☐ History & Physical	☐ X-Ray CD
☐ Billing Records	☐ Immunizations	☐ X-Ray Reports
☐ Clinic Visit Notes	☐ Labs	☐ Complete Medical Record
☐ Consultations	☐ Progress Notes	☐ Other: ________________________________

Dates of Service Requested:

☐ Specific Date ☐ Range of Dates: _______________ to _______________ ☐ All Dates of Service

Requesting Information *FROM* the following facility:

☐ La Rabida Children's Hospital 6501 S, Promontory Drive, Chicago, IL 60649 P: 773-753-8674; F: 773-363-6335

☐ La Rabida Joli Burrell Children's Advocacy Center, 200 Lakewood, Park Forest, IL 60466 P:708-481-9799; F: 708-481-9551

☐ Chicago Child Trauma Center, 1525 E. 55th Street, Suite 203, Chicago, IL 60615 P: 773-374-3748; F: 773-374-6223

☐ Children & Family Connections, 1525 E. 55th Street, Suite 203, Chicago, IL 60615 P: 773-374-7434; F: 773-324-7469

☐ Other: Facility Name: ____

Address: ____

City/State/Zip Code: ____

Phone: ________________________________ Fax: ________________________________

Section III: RELEASE REQUESTED PROTECTED HEALTH INFORMATION TO:

Please release this information to the following:

☐ La Rabida Children's Hospital 6501 S. Promontory Drive, Chicago, IL 60649

☐ Other: Facility Name: ____

Address: ____

City/State/Zip Code: ____

Phone: ________________________________ Fax: ________________________________

For the purpose of:

☐ Care Coordination/Case Management ☐ Legal ☐ Continuity of Care ☐ Personal Use ☐ Insurance

☐ DCFS/Government Agency ☐ Other: (Specify) ____

I would like the requested information in the following format:

☐ Paper ☐ Email ☐ USB ☐ Verbal Only

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Section IV: SPECIFIC CONSENT

The Health Information Portability and Accessibility Act of 1996 (HIPAA) has special protections for certain types of information that may be requested for use and/or disclosure. *By checking any of the boxes below, I am specifically authorizing La Rabida Children's Hospital to use and/or disclose the category of confidential information indicated:*

☐ Information about domestic abuse of an adult with a disability
☐ Information about child abuse and neglect
☐ Information about genetic testing
☐ Information about sexual assault/abuse
☐ Information about a mental illness or developmental disability *(a witness signature is required)*

Under the Consent by Minors to Health Care Services Act of the State of Illinois (410 ILCS 210), certain information requires the signature of any patient 12 years of age or older. *This information will not be released by La Rabida Children's Hospital without the patient's signature.* Please indicate the information requested, and provide the patient signature:

☐ Behavioural Health information and/or psychotherapy notes
☐ Information about substance abuse/use (alcohol or drug)
☐ Information about HIV/AIDS-related conditions
☐ Information about birth control and/or pregnancy
☐ Information about sexually transmitted disease(s)

______________________________ ______________________________
Patient signature Date

Section V: EFFECTIVE DATE(S) OF AUTHORIZATION

This authorization will remain in effect under the following conditions (please check only one):

☐ From the date of this authorization, until the following date: ______________________________
☐ Until the purpose of this authorization is fulfilled
☐ Other: ______________________________

If not otherwise specified, this authorization will expire within 90 days of the authorizing signature.

By signing below, I understand the following:

1. I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department of La Rabida Children's Hospital. I understand the revocation will not apply to information that has already been released;
2. I have the right to inspect or copy any information used or disclosed as a result of this authorization;
3. The information I authorize disclosed to another person or entity may be re-disclosed by that person or entity, and will be no longer protected by federal privacy regulations;
4. I may refuse to sign this authorization; and
5. My refusal to sign this authorization will not affect my ability to receive/obtain care at La Rabida Children's Hospital.

______________________________ ______________________________
Signature of Patient or Parent/Legal Guardian Date

______________________________ ______________________________
Printed Name of Patient or Parent/Legal Guardian Relationship to Patient

______________________________ ______________________________
Signature of Witness (only necessary when specifically indicated above in release) Date

____
Printed Name of Witness