  
  
 **Authorization to Release Protected Health Information** *Instructions: If any section is incomplete, this form may be invalid.*

|  |  |  |
| --- | --- | --- |
| Name (First, Middle, Last) | Birth Date (Month, DD, YYYY) | Phone No.:   (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ |
| Address | City, State, Zip | |

Shirley Ryan AbilityLab, 355 E.   
 Erie Street, Chicago, IL 60611  
   
 In care of:  
  
  Other  Same person and address noted above  
   
 Name:   
  
 Address:   
  
  
 Phone: Fax:

**Release Information To:**

**Release Information From:**

Shirley Ryan AbilityLab, 355 E.   
 Erie Street, Chicago, IL 60611  
   
  Other:   
   
 Name:  
   
 Address:  
   
   
   
 Phone: Fax:

**Service Dates**

From: To:

**Information To Be Released (check all that apply)**

**Purpose of Release**

Treatment/Continued Care  Personal  Legal Purposes

Insurance  Disability Determination  Other:

Abstract (History & Physical, Discharge Summary, Consultation Reports, Test Results, Therapy Notes)   
  Progress Notes  Operative/Procedure/Pathology Reports  Lab Results   
  Diagnostic/Radiology  Billing Information   
  Other:

The following information will be released only if I check below and include a witness signature:

Psychiatric/mental health and/or developmental disabilities information.  If the patient is 12-17 years old, the patient must also sign here to   
 approve release:   
  
 Testing results, diagnosis, or treatment of HIV/AIDS-related illness

**Delivery**

Paper copies of the requested information will be mailed to the address above, unless one or more of the following options are selected:  
 Provide on CD  Pick-up  E-mail:

*I can revoke (take back) this Authorization at any time in writing to the Shirley Ryan AbilityLab Director of Medical Records, except to the extent that action has already been taken to release this information. This Authorization will remain valid unless revoked, but will expire 1 year after the date below. I can inspect a copy of my health information to be released. If I do not sign this Authorization, RIC will not release my health information, except in instances defined in its Notice of Privacy Practices or otherwise permitted by law. The Shirley Ryan AbilityLab will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that there may be copying and/or processing fees associated with this release, such pricing to be disclosed to me upon my request. The health information disclosed under this Authorization may be re-disclosed by the recipient to others. However, Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.*

*Signature of Patient or Authorized Representative Date*

*Relationship of Authorized Representative to Patient Witness  
(please provide a copy of the authorization when submitting this form)  
   
   
 Medical Records Department | 355 E. Erie Street | Chicago, IL 60611*

*(312) 238-1668 phone | (312) 238-2900 fax*