

Authorization to Release Protected Health Information

Instructions: If any section is incomplete, this form may be invalid.

Name: (First, Middle, Last) (PLEASE PRINT)	Birth Date (Month, DD, YYYY)	Phone No.: () -
Address		City, State, Zip Code

RELEASE INFORMATION FROM:

Shirley Ryan AbilityLab
355 E. Erie Street, Chicago, IL 60611

Other:
Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

RELEASE INFORMATION TO:

Shirley Ryan AbilityLab
355 E. Erie Street, Chicago, IL 60611

In care of: _____

Same person and address noted above

Other:
Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

SERVICE DATES

From: _____ To: _____

PURPOSE OF RELEASE

Treatment/Continued Care Personal Legal Purposes
 Insurance Disability Determination Other: _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

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, the Shirley Ryan AbilityLab 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
(please provide a copy of the authorization when submitting this form)

Witness