Shirley Ryan AbilityLab

The future of RIC Rehabilitation Institute of Chicago

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*