Authorization to Release Protected Health Information

Shirley Ryan AbilityLab®

PLEASE PRINT:

_____
FIRST NAME   MIDDLE NAME   LAST NAME

_____
DATE OF BIRTH (MM/DD/YYYY)   PHONE

_____
ADDRESS   CITY, STATE, ZIP CODE

RELEASE INFORMATION FROM:

☐ Shirley Ryan AbilityLab, 355 East Erie Street, Chicago, IL 60611

☐ Other

    Name   _____

    Address _____

                 _____

    Phone   _____

    Fax   _____

RELEASE INFORMATION TO:

☐ Shirley Ryan AbilityLab, 355 East Erie Street, Chicago, IL 60611

    In care of: _____

☐ Same person and address noted at the top of this form

☐ Other

    Name   _____

    Address _____

                 _____

    Phone   _____

    Fax   _____

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

☐ Secure E-mail (PRINT): _____

SERVICE DATES

FROM: _____

TO: _____

INFORMATION TO BE RELEASED (check all that apply)

☐ **Abstract** _(History and Physical, Discharge Summary, Consultation Reports, Test Results, Therapy Notes)_

☐ Billing Information

☐ Progress Notes

☐ Diagnostic/Radiology

☐ Lab Results

☐ Operative Procedure/Pathology Reports

☐ Other _____

The following information will be released **ONLY IF** you check an item(s) below:

☐ Psychiatric/mental health and/or developmental disabilities information. _If the patient is 12–17 years old, they must also sign here to approve release:_

    _____

☐ Testing results, diagnosis, or treatment of HIV/AIDS-related illness

☐ Pain Management

☐ Vocational Rehab

☐ Chaplaincy Notes

PURPOSE OF RELEASE

☐ Disability Determination   ☐ Personal

☐ Insurance   ☐ Treatment/Continued Care

☐ Legal Purposes

☐ Other _____

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 one 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.)