ILLINOIS BONE AND JOINT INSTITUTE, LLC

Authorization to Disclose/Release Protected Health Information

(Must be signed by patient or legal representative before medical records will be released)

Patient Name: _____ **Date of Birth**: _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

I authorize Illinois Bone and Joint Institute Medical Records Department to use/disclose a copy of the specified protected health information as indicated below to (recipient):

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Purpose or need for information: _____

I authorize the use/disclosure of the following protected health information from (dates) _____ to _____.

NOTE: *Federal regulations require a description of how much and what kind of information is to be disclosed

☐ Send the entire medical record (all information) to the above named recipient.

☐ Send only the following information to the above named recipient: _____

_____

*The following items must be initialed to be excluded from the use/disclosure of protected health information:

☐ HIV/AIDS related information/records
☐ Genetic testing information/records
☐ Mental health information/records
☐ Drug/alcohol diagnosis, treatment or referral

I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal will in no way affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. Unless revoked earlier, this authorization: ☐ is a 1-time request ☐ expires in 30 days ☐ expires in _____ days.

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____