JACKSON PARK HOSPITAL AND MEDICAL CENTER
AND THE FRIEDELL CLINICS

Authorization for Release of Protected Health Information

I,_____, hereby authorize Jackson Park Hospital and The Friedell
Patient Name or Authorized Agent

Clinics to release to: _____
Name of health care facility, physician, agency, etc.

_____
Street address, City, State, Zip Code

the following information contained in the patient record of _____
Patient Name

born _____, residing at _____
Patient Birth Date Patient address, city state, zip

_____
[enter dates(s) of service]

___ The entire medical record, **excluding** mental health treatment, alcoholism and/or drug abuse treatment, and HIV/acquired immune deficiency syndrome [AIDS].

_____

___ Laboratory Reports ___ X-ray Reports ___ Operative Notes

___ Other: _____

To be disclosed, the following items must specifically be checked:

___ Mental Health Treatment Records
___ Alcoholism Treatment Records
___ HIV/Acquired Immune Deficiency Syndrome [AIDS] Records

The purpose(s) of the authorization is (are): _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the Hospital may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the Hospital of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the Hospital has already relied on it to use or disclose my health information. Written revocation must be sent to the Privacy Officer. Absent such written revocation, this Authorization for Release of Confidential Health Information will be valid from _____to_____
Date Date

Signed: _____ Date: _____

If you were not the patient, please specify your relationship to the patient or your legal responsibility to the patient.

_____

Patient/guardian to be provided with a signed copy of this authorization.