LAWNDALE CHRISTIAN HEALTH CENTER
Loving God. Loving People.

Health Information Management
3860 W Ogden Ave., Chicago, IL 60623
Phone: 872-588-3120 Fax: 872-588-3131

Authorization to Release Health Information

Patient Information

Name: _____

Birthdate: _____

Phone: _____

☐ Release to patient named above

Release Information To

Person/Institution: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Information to be Released

☐ Immunization/Shot Records ☐ School Physical Form ☐ Laboratory Reports ☐ Billing Records

☐ Medical Records ☐ Prenatal Records ☐ Radiology Reports ☐ Other _____

Release of Confidential Documents. I explicitly authorize the release of the documents indicated below that are designated "confidential" in my medical record. Please initial each document type that you authorize to be released.

_____ Behavioral Health Documents
Initials

_____ **Other Confidential Documents** *Such as HIV/AIDS, Sexually Transmitted Diseases and Alcohol/Substance Use.*
Initials

Dates of Service Requested

☐ Most Recent Visit

☐ Last 2 Years

☐ Specific Dates: _____

Reason For Release

☐ Personal (Patient Request)

☐ Physician/Organization

☐ Other _____

Delivery Method Requested

☐ CD By Mail ☐ Paper For Pickup

☐ CD For Pickup ☐ Paper By Mail

☐ Secure eMail ☐ Fax

Fees may be incurred depending on the chart size (number of pages) and the delivery method.

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Health Information Management department, except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released. I understand that this authorization is voluntary and I may refuse to sign this authorization. The above named person/institution will not refuse to treat me based on whether I allow my health information to be used and disclosed by others. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. **I understand that this authorization is voluntary and may include sensitive information (relating to HIV/AIDS, behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse, and sexually transmitted diseases) in non-confidential documents in my medical record**. This authorization shall remain valid unless revoked but will expire 90 days from the date of my signature.

_____ _____ _____
Signature of Patient or Personal/Legal Representative. *Date* *Relationship to Patient (If signed by a personal representative)*

_____ _____
Signature of Adolescent Patient - Ages 12-17 (Required if disclosing confidential Information) *Date*

OFFICE USE ONLY

Attention Staff: *Please be sure to fill out your name/date below after receiving the form from the patient and verifying the patient's identity. If records are released, please check-off the "Records Released" box. Medical Records staff will communicate directly with the patient about delivery dates.*

Chart Number: _____ ☐ Records Released

Request Received/Verified By (Staff Name): _____ Date: _____