

CHICAGO LAKESHORE HOSPITAL
Authorization For Release of Information

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

SOC. SEC.# _____ PHYSICIAN: _____

I hereby authorize CHICAGO LAKESHORE HOSPITAL to send copies of (or verbalize) protected health information from my mental health/substance abuse/medical record to:

(Name of person, facility, institution)

(Address)

(City, State)

(Zip)

The following information may be released:

FACE SHEET _____	PSYCHIATRIC EXAM. _____	SCHOOL RECORDS _____
MED. HISTORY _____	TREATMENT PLAN _____	SOCIAL HISTORY _____
& PHYSICAL EXAM _____	PSYCHOLOGICAL EVAL _____	OTHER (Specify) _____
X-RAY REPORT _____	DISCHARGE SUMMARY _____	_____

HIV & AIDS STATUS AND RELATED DISORDERS; _____ (PLEASE INITIAL)
(Released Only Upon Specified Requests).

I authorize information to be released from the following time periods: _____ to _____.

I give my consent freely and voluntarily. I realize that treatment services will not be withheld if I do not consent to the release of this information.

This authorization is only valid through (enter exact date) _____ and is limited to only that information, I Have authorized to be released. I understand that I have the right to inspect and copy the information to be disclosed according to the policies and procedures of Chicago Lakeshore Hospital. It is further understood that I have the right to revoke this authorization at any time before records are sent out, by submitting a witnessed request in writing to Chicago Lakeshore Hospital, Health Information Management Department. I understand that my refusal to authorize this release will prevent disclosure of this information.

REDISCLASURE STATEMENT: Persons, agencies and institutions to which this information is disclosed are prohibited by state/federal law from redisclosure without the written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.

Signature of patient if a least 12 years old

Date

Signature of parent/guardian if patient
Is under 18 years of age

Relationship

Date

Signature of Witness

Date