

# Authorization for Use or Disclosure of Health Information

Patient Name \_\_\_\_\_

Mail Record \_\_\_\_\_ I Will Pick Up \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Phone Number \_\_\_\_\_ History # \_\_\_\_\_

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law, as described below:

1. Persons/organization authorized to make the disclosure (please include address):

\_\_\_\_\_

2. Persons/organization to whom the disclosure may be made (please include address):

\_\_\_\_\_

3. Specific description of the information to be used or disclosed (check all that apply and include dates of service, where applicable):

X-ray images \_\_\_\_\_

CT images \_\_\_\_\_

MRI images \_\_\_\_\_

Mammography images \_\_\_\_\_

Nuclear Medicine images \_\_\_\_\_

Ultrasound images \_\_\_\_\_

4. The protected health information will be used and/or disclosed for the following purposes:

Moving from the area                       Attorney request

Provider preference                       Other \_\_\_\_\_

5. Revocation/Expiration. This authorization can be revoked in writing at any time unless the clinic has already acted upon your request. Submit your written request to the Department of Life Imaging (Radiology). Without expressed written revocation, this authorization expires one year after it is signed, or upon the following specific date, event, or condition: \_\_\_\_\_.

6. I understand that any costs incurred in producing this information will be my responsibility. \_\_\_\_\_(initial)

My authorization to disclose the above information is voluntary, and Christie Clinic will not condition the provision of treatment on this authorization. I understand if I refuse to sign this form that the requested information will not be released. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by the laws and regulations applicable to Christie Clinic. If I have questions about use and disclosure of my health information, I may contact the Health Information Services Department.

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Signature of Patient (or Personal Representative) and Relationship to Patient

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Date

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Signature of Parent (if Minor Child) or Signature of Minor Age 12 to 17 Years

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Date

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Witness Signature

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Witness Printed Name

Date Picked Up \_\_\_\_\_ Initials \_\_\_\_\_  
(Please show identification when picking up images in person.)

**IMPORTANT NOTICE: ANY INFORMATION PROTECTED BY FEDERAL REGULATIONS GOVERNING SUBSTANCE ABUSE TREATMENT (42 CFR, PART 2) OR THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT IS PROHIBITED FROM FURTHER DISCLOSURE UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY 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. FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.**