AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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Patient Name_______________________________________Date of Birth _________________ Chart Number: ______________________

Address____

Phone Number: ____ Preferred Time: ____

I hereby authorize that the protected health information regarding the above-named person be forwarded as follows:

FROM	TO

Entire Medical Records: _____ Pathology/Blood Work ______ Diagnostic Test Dated from __________ to ____

Other: ____

MODE OF CONVEYANCE: Fax: _________________________ Mail ______ to be picked up by Myself _____

Other: ____

REASON FOR RELEASE OF RECORDS:

___ Moving ___ Insurance Conflict ___ 2nd Opinion ___ Transfer of Care ___ Primary Physician

Other: ____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that **if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:**

______Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse

______Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

______Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named Office/Institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

____ ____________________________
Signature of Patient Date

____ ____________________________
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient
(Required if Patient is not legally authorized to sign Authorization)

____ ____________________________
WITNESS Date

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that UpToDate Healthcare For Women cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

MINIMUM FEE DUE WITH RELEASE OF MEDICAL RFECORD AUTHORIZATION: Please carefully review page 2/2 for an understanding of Applicable Fee per Illinois Law for Release of Medical record. Authorization without a minimum of $25 along-with this duly signed and completed form will render this request void, emergencies excepted.

PATIENT COPYING CHARGE NOTIFICATION SHEET

USE THIS SHEET WHEN THE COPY OF THE MEDICAL RECORD IS BEING PROVIDED DIRECTLY TO THE PATIENT OR HIS OR HER REPRESENTATIVE FOR HEALTH CARE DECISIONS. YOU MAY CHARGE THE PATIENT NO MORE THAN THE LOWER AMOUNT FROM THESE TWO CALCULATIONS.

Number of pages to be copied: ________ pages

Calculating the amount allowed under Illinois law:

Handling Fee			$24.44
Per Page Charges			
	Pages 1-25	$0.92 per page	$
	Pages 26-50	$0.61 per page	$
	Page 51 and over	$0.31 per page	$
Mailing Charges			$
Maximum Charge Under Illinois Law			$

Calculating the amount allowed under HIPAA:

Duplicating Machine Cost (number pages times cost per page)		$ per page	$
Staff Costs			
	Cost of copying 1st page		$
	Cost of copying additional pages	$ per page	$
Mailing Charges			$
Maximum Charge Under HIPAA			$

Lower of Illinois law and HIPAA Charges: $_____________