

Please contact your IBJI physician's Medical Records department after you have completed this form for directions on what to do with it.



ILLINOIS BONE AND JOINT INSTITUTE, LLC

Authorization to Disclose/Release Protected Health Information

Patient Name: _____ **Date of Birth:** _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

I authorize Illinois Bone and Joint Institute Medical Records Department to use/disclose a copy of the specified protected health information as indicated below to (recipient):

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Purpose or need for information: _____

I authorize the use/disclosure of the following protected health information from (dates) _____ to _____.

NOTE: *Federal regulations require a description of how much and what kind of information is to be disclosed

Send the entire medical record (all information) to the above named recipient.

Send only the following information to the above named recipient: _____

*The following items must be initialed to be excluded from the use/disclosure of protected health information:

- | | |
|---|--|
| <input type="checkbox"/> HIV/AIDS related information/records | <input type="checkbox"/> Genetic testing information/records |
| <input type="checkbox"/> Mental health information/records | <input type="checkbox"/> Drug/alcohol diagnosis, treatment or referral |

I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal will in no way affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. Unless revoked earlier, this authorization: is a 1-time request expires in 30 days expires in _____ days.

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____ Relationship: _____