AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: _____

_____

_____

MY HIGHLY CONFIDENTIAL INFORMATION:
Without limiting the information specified above, by checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse
- ☐ Psychotherapy notes of a mental health professional
- ☐ Information about mental health or developmental disability services
- ☐ Alcohol/drug abuse treatment program records and information
- ☐ HIV/AIDS test results
- ☐ Other: _____

RECIPIENT: Name of person or class of persons to whom Pain Specialists of Greater Chicago (the "Practice") may disclose my health information:

_____

_____

_____Address,Phone & Fax #

of the recipient or where my health information should be delivered:_____

_____

_____

TERM: This Authorization will remain in effect:

PAIN SPECIALISTS OF GREATER CHICAGO

7055 HIGH GROVE BLVD• SUITE 100 • BURR RIDGE, IL 60527

Ph.: 630-371-9980 •• Fax: 877-295-7647

☐ From the date of this Authorization until _____ __, 20__
☐ Until Practice fulfills this request
☐ Until the following event occurs: _____

PURPOSE: I authorize the Practice to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

_____
_____

I understand that once Practice discloses my health information to the recipient, Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes alcohol or drug abuse treatment program records or information, the confidentiality of the records or information is protected by federal law (42 C.F.R. Part 2) that prohibits re-disclosure except with my specific written consent.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Practice; except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Practice's Privacy Office by mail at 7055 High Grove Boulevard, Suite 100, Burr Ridge, Illinois 60527 or by telephone at (630) 371-9980.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient **Date**

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Authorized Personal Representative | Relationship to Patient | Date

PAIN SPECIALISTS OF GREATER CHICAGO

7055 HIGH GROVE BLVD• SUITE 100 • BURR RIDGE, IL 60527

Ph.: 630-371-9980 •• Fax: 877-295-7647