



AUTHORIZATION FOR RELEASE OF INFORMATION FROM Howard Brown Health Center

DATE: _____

I, _____
Last Name First MI

Date of Birth: _____ SSN: _____

Address: _____ Phone: (____) _____
Street City State Zip

hereby authorize and request:

*Howard Brown Health Center
4025 N. Sheridan
Chicago, IL 60613
Medical Records Department
773-388-8667 phone
773-388-8936 fax*

*TRIAD Health Practice
3000 N Halsted St. 711
Chicago, IL 60657
Medical Records Department
773-296-8400 phone
773-296-8401 fax*

To provide information to: _____

Healthcare Provider/Address/Phone Number and Fax Number

This information will be used for the purpose of: _____

and is confined to the following *specified information*:

(INITIAL all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Psychiatric Treatment Records |
| <input type="checkbox"/> Alcohol & Drug Abuse Records | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> HIV/AIDS, if applicable |
| <input type="checkbox"/> EKG/EEG | <input type="checkbox"/> Other (specify below): |
| <input type="checkbox"/> Laboratory Reports | |

And the following date(s) of treatment:

Dates seen: _____ Department where seen: _____

THIS AUTHORIZATION IS VALID UNTIL: _____
(must have date within next 12 months)

I understand that I may revoke this authorization at any time by writing to the address above. This revocation is not applicable to records already released in good faith pursuant to the above release. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

It has been explained to me that if I decline to consent to this release of information, the following are the consequences: Specify (if any): unable to coordinate care, apply for this program, and/or records not released.

Signature of Person Authorizing Date Signature of Witness Date

NOTE:
Authorization must be filled out in its entirety in order to be valid

if signature of person giving authorization is different from person receiving healthcare, indicate basis on which consent is given: