AUTHORIZATION FOR RELEASE OF INFORMATION TO Howard Brown Health Center

DATE: ____________________________

I, ________________________________ ____________________________ _______
Last Name **First** **MI**

Date of Birth: _______________________ **SSN:** ________________________

Address: ____ ________ **Phone:** (____) ________________
Street **City** **State** **Zip**

hereby authorize and request (**HealthCare Provider, Address, Phone Number and Fax Number**):

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To provide information to*:*

Howard Brown Health Center	*TRIAD Health Practice*
4025 N. Sheridan	*3000 N Halsted St. 711*
Chicago, IL 60613	*Chicago, IL 60657*
Medical Records Department	*Medical Records Department*
773-388-8667 phone	*773-296-8400 phone*
773-388-8936 fax	*773-296-8401 fax*

This information will be used for the purpose of: ____
and is confined to the following ***specified information***:
(**INITIAL** all that apply)

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

____

And the following date(s) of treatment:
Dates seen: ____________________________ **Department where seen**: _____________________________

THIS AUTHORIZATION IS VALID UNTIL: ____
(**must have date within next12 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:
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Revised 6-2010