



850 W. Irving Park Road Chicago, IL 60613-3098 Ph: 773-975-6813 Fax: 773-525-7168

**AUTHORIZATION TO DISCLOSE PRIVILEGED
MEDICAL INFORMATION OR REVIEW OF MEDICAL RECORDS**

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: ____/____/____ Social Security Number: _____ Telephone (____) _____

Description of information that may be disclosed: **Date(s) of Treatment:**
____ INPATIENT _____
____ OUTPATIENT _____
____ EMERGENCY ROOM _____
____ CLINIC _____
____ OUTPATIENT SURGERY _____
____ OUTPATIENT RADIOLOGY (X-Ray) _____
____ OUTPATIENT LABORATORY _____
____ OTHER _____

I hereby authorize Thorek Memorial Hospital to: DISCLOSE TO: OBTAIN FROM:
Person / Facility _____
Address _____
City, State, Zip _____

I am authorizing Thorek Memorial Hospital to release sensitive information as indicated:
 AIDS / HIV Sexual Assault Behavioral Health
 Drug / Alcohol Abuse Child Abuse Developmental Disabilities

This information will be used for the following purpose:
 Continuing Care Personal Legal Other _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligible for benefits. I understand that I may revoke this authorization at any time by notifying the HIM department in writing. However the revocation will not be valid if (a) Action has been taken in reliance on this authorization, or (b) If the authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.
This authorization will expire: _____
(Date, Event or Condition upon which consent expires)

Signature of Patient or Legally Authorized Patient Representative Date of Signature

Relationship to Patient

Signature of Witness Date of Signature