AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR RESEARCH

PURPOSE AND INSTRUCTIONS:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule authorize us to use and disclose your Protected Health Information, without your authorization or consent, for treatment, payment and health care operations activities. However, we may need your written authorization in order to use and disclose your Protected Health Information for some research activities. We will not deny you treatment or care if you refuse to sign this Authorization, however, if you do not sign this Authorization you will not be able to participate in the research study described below. If you agree to allow us to use and disclose your Protected Health Information for research, please complete and sign this Authorization.

(Please Print Legibly)

Patient Name (Last, First, Middle)		Medical Record Number	
Street Address		SSN or other ID (Please indicate other by name)	
City	State	Zip Code	Telephone

I, _____[Your Name], authorize _____ (the "Provider") to use and to disclose the Protected Health Information specified below to _____ [Identify recipient]

[*If the recipient is intended to be health care providers participating in the health information exchange, then insert the following language above*—other health care providers, including but not limited other health care providers participating in the health information exchange ("Exchange") who may request such information for research purposes and I hereby specifically authorize Provider to release my Protected Health Information to the Exchange and researchers for that purpose].

Protected Health Information to be Disclosed: Specifically and meaningfully describe the Protected Health Information authorized to be disclosed for research:

_____

My authorization to disclose Protected Health Information for research purposes specifically includes the disclosure of the following categories/types of Protected Health Information . **UNDER ILLINOIS LAW, YOU MUST INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE FOR RESEARCH**:

_____ Alcohol Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ Drug Abuse Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ Mental Health and Developmental Disability Treatment Records (please initial) (Your authorization to disclose is valid for one (1) year from the date of date of this Authorization)
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records (please initial)
_____ Hepatitis B or C Testing Records (please initial)
_____ Genetic Testing Records (please initial)

EXPIRATION

Except as otherwise specifically provided above, my authorization to use my Protected Health Information for research and to disclose my Protected health Information to other health care providers in the Network for research is valid for the for the time period between _____ (date) and _____ (date/event).

RE-DISCLOSURE

I understand that, except as otherwise specifically prohibited by Illinois or federal law, the Protected Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. Participants in the Exchange, including Provider, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

REVOCATION

I understand that I may revoke this Authorization, in whole or in part, by sending a written and dated notice to the Provider. Notice of your revocation of this Authorization should be sent to:

_____
_____
_____

Your revocation of this Authorization will not apply to any uses and disclosures made prior to the acceptance of your revocation by Provider and you hereby acknowledge that Provider is released from any and all responsibility or liability for disclosure of the above information to the extent indicated and authorized by this Authorization prior to Provider's acceptance of its revocation.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED TO PERMIT DISCLOSURE

I understand the purpose of this Authorization and agree to the disclosure of my medical and health information for research as set forth herein.

Signature Date

Authority of Personal Representative (if applicable):_____

Identify Verified by: ☐ Photo ID, ☐ Matching Signature, ☐ Other, Specify

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.