CONSENT FOR USE AND DISCLOSURE OF CERTAIN TYPES/CATEGORIES OF PROTECTED HEALTH INFORMATION

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, in certain situations we may need your prior written consent in order to disclose certain categories/types of Protected Health Information under other state or federal laws. We will not deny you treatment or care if you refuse to sign this Consent, but we may not be able to share all of your relevant health information with other health care providers involved in your treatment and care. If you agree to allow us to disclose some or all of the requested Protected Health Information, please complete and sign this Consent.

(Please Print Legibly)

<table>
<tr><td colspan="2">Patient Name (Last, First, Middle)</td><td colspan="2">Medical Record Number</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="2">SSN or other ID (Please indicate other by name)</td></tr>
<tr><td>City</td><td>State</td><td>Zip Code</td><td>Telephone</td></tr>
</table>

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

[If the recipient is intended to be health care providers 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 treatment, payment and health care operation purposes. The Exchange facilitates the electronic exchange of medical and other individually identifiable health information among health care providers that participate in the Exchange for patient treatment, payment and health care operations].

[*For use with the Exchange:* I understand the purpose of the electronic disclosure of my medical and health information to other health care providers that participate in the Exchange is to facilitate my medical treatment (both primary and specialty care), arrange for payment for health care services provided to me and for other administrative purposes by the participants in the Exchange]. I understand the information to be disclosed includes the medical [and billing] records used to make decisions about me. For example, my record may include the following kinds of Protected Health Information:

- Demographic (name, age, address, etc.);
- Medical (diagnosis, treatment history, referrals to other providers, *etc.*); and,
- Encounter Data (description of services provided).\

EXCEPT AS OTHERWISE PERMITTED OR REQUIRED BY ILLINOIS LAW (E.G., FOR PUBLIC HEALTH REPORTING PURPOSES), YOU MUST INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES:

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

REVOCATION

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

_____
_____
_____

Your revocation of this Consent will not affect any 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 Consent prior to Provider's acceptance of its revocation.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED TO PERMIT DISCLOSURE

I understand the purpose of the Network/Exchange and this Consent and agree to the disclosure of my medical and health information 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 CONSENT AFTER YOU SIGN IT.