AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE ILLINOIS HEALTH INFORMATION NETWORK

PURPOSE:

The Illinois Health Information Network ("Network") is an Illinois not-for-profit corporation authorized by law to create a state-level network to facilitate the electronic exchange of medical and other individually identifiable health information among health care providers that participate in the Network for patient treatment, payment and health care operation purposes. The Network does not house or store any data; rather, it merely facilitates exchange of data among participating health care providers. The Network is also authorized by law to collect [de-identified] health data from participating health care providers into a central repository for public health purposes and to make health information and de-identified data available to approved researchers.

INSTRUCTIONS:

In order for us to disclose certain types and categories of your Protected Health Information, as specified below, to other health care providers that participate in the Network and to researchers, we need to obtain your prior written authorization. We will not deny you treatment or care if you refuse to sign the attached Authorization, but we will not be able to share all of your relevant health information with other health care providers that participate in the Network or with approved researchers if you fail to sign the Authorization. If you agree to allow us to disclose some or all of requested Protected Health Information, please complete and sign the attached 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 disclose the Protected Health Information specified below to other participating health care providers in the Illinois Health Information Network ("Network") who may request such information. I understand the information to be disclosed includes the medical [and billing] records used to make decisions about me. I understand the purpose of the electronic disclosure of my medical and health information to other health care providers that participate in the Network 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 Network. 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).

YOU MUST INITIAL EACH CATEGORY/TYPE OF PROTECTED HEALTH INFORMATION AUTHORIZED TO BE DISCLOSED:

_____ Alcohol Treatment Records (please initial)
_____ Drug Abuse Treatment Records (please initial)
_____ Mental Health Treatment Records (please initial)
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records (please initial)
_____ Hepatitis B or C Testing Records (please initial)
_____ Genetic Testing Records (please initial)
_____ Other (Please specify _________________________)(please initial) **[TO BE DISCUSSED]**

DISCLOSURE FOR RESEARCH

I also understand that the Network may, in accordance with law, also facilitate the disclosure of Protected Health Information to persons for research purposes and I hereby specifically authorize Provider to release my Protected Health Information to the Network and researchers for that purpose.

_______ (please initial). My authorization to disclose my medical and other health information to the Network for research is valid for the for the time period between ___________ (date) and _____________ (date).

My authorization to disclose Protected Health Information for research purposes includes the disclosure of the following categories/types of Protected Health Information . **YOU MUST INITIAL EACH CATEGORY/TYPE OF PROTECTED HEALTH INFORMATION AUTHORIZED TO BE DISCLOSED FOR RESEARCH**:

_____ Alcohol Treatment Records (please initial)
_____ Drug Abuse Treatment Records (please initial)
_____ Mental Health Treatment Records (please initial)
_____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records (please initial)
_____ Hepatitis B or C Testing Records (please initial)
_____ Genetic Testing Records (please initial)
_____ Other (Please specify _________________________)(please initial) **[TO BE DISCUSSED]**

RE-DISCLOSURE

I understand that 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 Network, 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. The revocation will not apply to any disclosures made prior to the receipt of the revocation by Provider.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED TO PERMIT DISCLOSURE

I understand the purpose of the Network and this Authorization 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 AUTHORIZATION AFTER YOU SIGN IT.