CONSENT 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 for 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 researchers.

INSTRUCTIONS

Except as set forth below, we are authorized by law to use and disclose your Protected Health Information for treatment, payment and health care operation purposes without your consent. Nonetheless, we seek your consent to use and disclose your Protected Health Information to other health care providers that participate in the Network. ***[CONSIDER CONSEQUENCES, IF ANY, OF ASKING FOR BUT NOT OBTAINING PATIENT CONSENT.]***

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 relevant portions of the attached Consent, 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 Consent. If you agree to allow us to disclose some or all of requested protected health information, please complete the relevant portions of and sign the attached Consent.

(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

INFORMATION THAT WILL BE DISCLOSED; PURPOSE OF THE CONSENT FOR DISCLOSURE

I, ____[Your Name], hereby consent to the disclosure of my medical, health and encounter information by __________________________ (the "Provider") to other participating health care providers in the Illinois Health Information Network ("Network") who may request such information for treatment, payment and health care operation purposes. 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).

SPECIFIC AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE, MENTAL HEALTH, HIV/AIDS, HEPATITIS B OR C, AND GENETIC INFORMATION

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE THE FOLLOWING TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTH CARE PROVIDERS THAT PARTICIPATE IN THE NETWORK FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES. 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**]

AUTHORIZATION FOR 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 information disclosed pursuant to this consent may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 and 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 consent, in whole or in part]** or **[those portions of this consent authorizing the disclosure of selected categories of my Protected Health Information and/or my authorization to disclose my Protected Health Information for research]** 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 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.