# CONSENT FOR USE AND DISCLOSURE OF CERTAIN TYPES/CATEGORIES 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, we do need your prior written consent in order to disclose certain categories/types of your Protected Health Information under Illinois law. 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)

| 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 _____[Identify recipient]

[If the recipient is intended to be health care providers in the Network/Exchange, then insert the following language above—other health care providers, including but not limited other health care providers participating in the Illinois Health Information Network/Exchange ("Network/Exchange") who may request such information for treatment, payment and health care operation purposes. The Network/Exchange is a state-level network/exchange 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 operations].

[For use with the Network/Exchange: I understand the purpose of the electronic disclosure of my medical and health information to other health care providers that participate in the Network/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 Network/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).

**UNDER ILLINOIS LAW, YOU MUST INITIAL EACH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE:**

_____ 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. 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/Exchange 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 CONSENT AFTER YOU SIGN IT.**