www.odhcil.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ___________________________ Date of Birth:________________ SSN:__________________
Address: _________________________________City:________________ State:_______ Zip:________
Phone:_____________________ Email (optional):____

I hereby authorize and request that: **Open Door Clinic**

1665 Larkin Avenue, Elgin, Il 60123

Phone (847) 695-1093 / Fax (847) 695-0501/ (630) 800-1062

Disclose information to me_____

- Disclose information TO_____ Receive Information From________ Exchange Information With_________

____

____

City: ______________________ State: _________ Zip: __________________

Phone: ___________________ Fax: ________________________________

Conditions or limits on disclosure (optional): ____

I request the release of the following information (INITIAL ALL THAT APPLY):*

______COMPLETE HEALTH RECORD _____X-rays _____Lab Tests/Reports
______Discharge Summary _____Radiology _____Case Management Notes/Reports
______History and Physical Exams ____EKG/EEG _____COVID test results/employer letters
______Physician/Consultation Reports ____Progress Notes _____Other: ______________________

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

______Mental/Behavioral Health ________Sexually Transmitted Diseases _______Developmental Disability
______HIV/AIDS ________Alcohol/Substance Abuse _______DNA Testing/Genetic Disorders
______ Domestic Violence/Sexual ________Assault ANY AND ALL OF THE ABOVE-LISTED CONDITIONS/TREATMENTS

Purpose of disclosure: ____________________Date/range of requested information (if applicable):___________

<u>FOR TEXT, VOICEMAIL/ANSWERING MACHINE, OR EMAIL DELIVERY OF INFORMATION (to patient only):</u>

I understand that text, voicemail, or email delivery may not be secure, and that Howard Brown Health cannot guarantee the privacy or security of my phone number, email address, or related device(s). I understand this risk and consent to and authorize the delivery of the information requested above to me, as follows (check all that apply):

____ by text message at the telephone number indicated above.

____ by leaving a voicemail or voice message at the telephone number indicated above.

____ by sending an email to the email address indicated above

This Authorization is valid for one year or until (select date no more than 12 months from signature) __________________

I UNDERSTAND THAT THIS AUTHORIZATON IS VOLUNTARY, AND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ADDRESS ABOVE. ANY REVOCATION DOES NOT APPLY TO RECORDS ALREADY RELEASED IN GOOD FAITH PURSUANT TO THE ABOVE RELEASE. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION BEING DISCLOSED PURSUANT TO THIS AUTHORIZATION. I UNDERSTAND THAT A MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION, BUT IT HAS BEEN EXPLAINED TO ME THAT IF I DECLINE TO CONSENT TO THIS RELEASE OF INFORMATION, THE FOLLOWING CONSEQUENCES MAY APPLY, AS RELEVANT: MY PROVIDERS MAY BE UNABLE TO COORDINATE MY CARE; I MAY BE UNABLE TO APPLY FOR THIS PROGRAM; AND/OR THE REQUESTED RECORDS MAY NOT BE RELEASED. ANY COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

________________________________ _________ _____________________________ __________

Signature of Person Authorizing Release Date Signature of Witness (*Required for Mental/Developmental Health Records)

Date NOTE: This Authorization must be completed and signed in order to be valid. If the authorization signature is from a person other than the person receiving care, indicate the basis of the authorization and consent:

***Requests for records may incur a charge, if and as allowed by law**.