HEARTLAND HEALTH CENTERS
HEALTHCARE FROM THE HEART

RELEASE OF INFORMATION

Patient Name: _____ **MRN:** _____
Last First MI

Date Of Birth: _____/_____/_____ **Phone:** _____
Month Day Year

I authorize Heartland Health Centers to release medical records (which may be copied, orally communicated, or faxed) from *my* record as stated below

Information to be released FROM:	Information to be released TO:
Heartland Health Centers Medical Records Office 845 W Wilson Ave Chicago, IL 60640 **Phone**: **872-260-3852** **Fax** : **773-437-6812**	**Organization/Person Name** **Street Address** **City, State, Zip** **Phone:** **Fax:**

Sensitive Information (Initial below if you do NOT want the following info to be disclosed):

___HIV/AIDS ___Mental Health ___ Alcohol/Substance Use ___ Genetic Testing

For the following dates of treatment: -- to___/___/___ (If blank, we will release records from the past 12 months)

Type of information (entire record will be released unless specified) _____

Purpose of Disclosure: ☐ Transfer of care to another provider ☐ Referral/Consultation ☐ Insurance claim
☐ Personal use ☐ Disability determination ☐ Other:

This authorization is valid until __/__/__ (Date not to exceed 1 year)

I acknowledge that I have fully reviewed and understand the contents of \his form. I acknowledge that a photocopy or fax of this form Is valid.I understand that

I have the right to Inspect and receive a copy of the Information to be disclosed.

I understand that I may refuse to consent to the release of the above Information and that I may revoke this authorization at any time except to the extent action has already been taken.

I understand that *my* consent Is voluntary: however, my refusal may hamper further evaluation or treatment.

I understand that If the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health Information privacy laws, they may further disclose the PHI and It may no longer be protected by federal health Information privacy laws.

I understand that If the patient is 12-17 years old, the patient must sign this consent in order to disclose certain protected information, pursuant to the Consent by Minors to Medical Procedures Act and the Mental Health and Developmental Disabilities Confidentiality Act

_____ _____
Signature of Patient or Legally Authorized Representative **Date**

_____ _____
Signature of Minor if Patient is 12-17 years old **Date**

_____ _____
If Not Patient, then Name and relationship to Patient (for example: Parent) **Date**

_____ _____
Signature of Heartland Health Centers Staff Member **Date**