



FRIEND FAMILY HEALTH CENTER, INC.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name (Please Print) Last First MI Birth Date MRN

Address City State Zip

Phone # (Home) (Work/Other) Last 4 Digits of SS#

Would you like to receive your records electronically? (HealthPort is responsible for processing records electronically) Yes No
Email address: (required if electronic delivery is desired)

I AUTHORIZE:

- Cottage Grove 800 E. 55th St. Chicago, IL 60615
Western 5843 S. Western Ave. Chicago, IL 60636
Beethoven 25 W. 47th St. Chicago, IL 60609
Pulaski 5635 S. Pulaski Rd. 2nd Fl. Chicago, IL 60629
Ashland 4802 S. Ashland Ave. Chicago, IL 60609

TO: Send Information to Obtain Information from Other

Name/Physician or Facility

Address City State ZIP

Phone Number Fax Number

Reason for Release:

- Transfer of care to another provider Legal Use Insurance/Benefit Use Continuation of Care Specialty Provider
Transition of care Copy for personal record Social Security/Disability Other

Records that I authorize the use or disclosure of: COMPLETE RECORDS or check all that apply below:

- OB/Prenatal Records Visit/Progress Notes Diagnostic/Imaging Reports for CT / PET / X-Ray / VQ
Problem List Immunization Record Case Management Notes
Medication List Lab Reports Breathing Tests

Other:

Dates of Service: (from) (through)

I recognize that the following information is protected from release by federal or state law without specific authorization. I specifically consent to the use or disclosure as indicated below: (please initial next to each type of records)

- Aids/HIV Alcohol Treatment Counseling Notes
Substance Abuse Notes STD's Psychiatric Visit Notes

I understand the following:

- This facility has partnered with HealthPort Technologies, LLC. I understand that in compliance with Illinois State law, there may be fees for records.
I understand this authorization is voluntary. Friend Family Health Center will not condition treatment, payment or enrollment in a health plan or eligibility for benefits on whether I authorize this release.
I understand that this authorization will expire on (enter date or event). In the event the date is not entered, this authorization will expire one year from date indicated below.
I understand that I have the right to revoke this authorization at any time by notifying Friend Family Health Center in writing. This will not apply to records that have already been released. Send notice to: Privacy Officer, Friend Family Health Center, 800 East 55th St. Chicago, IL 60615.
Once the records are released, the clinic releasing records cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.
I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also have the right to refuse to sign this authorization.

Date (Signature of Client or Personal Representative) Date (Signature of Parent or Guardian, if required)

Reason patient is unable to sign: Minor Deceased Other:

Notice to Whomever Disclosure is made: This information has been disclosed to you from records whose protected health information is protected by State and Federal Law including 42 CFR Part 2. These laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains.