Advocate Health Care | Aurora Health Care

Instructions for Completing the Authorization for Release of Information Form

To authorize the release of your protected health information, you may submit a request online through the LiveWell Patient Portal or submit a completed Authorization for Release of Health Information Form using the instructions below.

Important: One patient per form. Patients or authorized representatives must carefully read and complete every section of the form prior to signing and dating to ensure the request is valid and complete.

1. **Patient Information:** Please complete all required patient information, including the patient's full name, date of birth, street address, city, state, ZIP code, telephone number, and email address.
2. **Treatment Facility/Physician:** Please list the name of the hospital, doctor's office, clinic, or other healthcare facility where you received care. If known, you may also include the name of the treating physician.
3. **Treatment Dates:** Please list the dates of treatment for the records you are requesting (for example, hospital admission and discharge dates or dates of office visits). If you do not know the exact dates, you may provide an estimated timeframe or date range.
    A. **Behavioral Health Only –** Ignore the check box if the patient is receiving their own records. This box is only used of the patient is allowing back and forth exchange of their health information between the receiving entity with the releasing entity.
4. **Information Requested:** Please select all applicable types of information being requested.
    A. For **medical records**, choose the specific parts of the medical record you would like to receive.
    B. For **imaging**, select the type of images you need under the Imaging section.
    C. For **billing** information, select the appropriate billing records under the Billing section.
5. **Release the Requested Information to:** Please provide the full name of the recipient (facility, person, or company), including the street address or PO Box, city, state, ZIP code, phone number, fax number, and email address.
6. **Purpose of Request:** Select the purpose for which the information is being released (e.g., continuation of care, personal request, legal, insurance, or other).
7. **Requested Format/Delivery Method:** Please choose how you would like to send the requested information by selecting an option under **Mail, Electronic**, or **Other**. Please note that **fees may apply** depending on the delivery method selected
8. **Review & Authorize:** Please review the Your Rights Regarding this Authorization section carefully.

    Please include an expiration date for the release of records, if applicable. If no expiration date is provided, the authorization will automatically expire in one year from date of signature.

    Once reviewed print your name, sign, and date the form to authorize the release of the requested medical information. Typed signatures are not accepted. If the patient is unable to sign or lacks legal capacity, an authorized representative may sign on the patient's behalf; supporting documentation may be required.

    If the patient is a minor, the minor may sign this authorization if they consented to treatment for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for substance use or alcohol. If the minor received substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign.