Advocate Health Care | Aurora Health Care

Authorization to Release Protected Health Information

Patient Information: **(One Patient Per Form)**

Patient Name: _____   Date of Birth: _____

Street Address: _____   City, State, Zip: _____

Telephone: _____   Email: _____

Treatment Facility/Physician: _____

Treatment Dates: _____

☐ Check here if Information will be mutually exchanged (allows both the sender and recipient(s) to share the information below with each other) this is for Behavioral Health information only.

Information Requested (select all that apply):

Medical Records	Imaging (requires CD format)	Billing
☐ Facility Summary (includes all items in **bold**)	☐ Radiology Images (X-Ray/CT/MRI/US)	☐ Itemized Bill(s)
☐ **Discharge Summary** ☐ Sleep Study Reports	☐ Cardiology Images (Echo/Cath Lab)	☐ UB04 Form
☐ **History & Physical** ☐ Entire Medical Record	☐ Neurology Images (EEGs)	☐ CMS 1500 Form
☐ **Consultation Reports** ☐ Other: _____	☐ Fetal Ultrasound Images	☐ Other Billing:
☐ **Office/Progress Notes** **Behavioral Health**	☐ Other Imaging: _____	_____
☐ **Emergency Record** ☐ Treatment Records		
☐ **Operative Reports** (Treatment Plans & Notes,		
☐ **Laboratory Reports** Assessment, Psych Eval,		
☐ **Pathology Reports** Labs, Medications)		
☐ **Radiology Reports** ☐ Psychological Test Results		
☐ **Immunizations** ☐ Legal Status/Court Records		

Release the Requested Information to:

_____

(Name of Facility, Person, Company)   (Street Address or PO Box, City, State, ZIP Code)

_____

(Phone Number)   (Fax Number)   (Email Address)

Purpose of Release:

☐ Continuation of Care   ☐ Personal (at my request)   ☐ Legal/Investigation   ☐ Insurance   ☐ Other: _____

Requested Format/Delivery Method: *(Fees may apply)*

By Mail:	**Electronically:**	**Other:**
☐ Paper Copy	☐ Encrypted Email	☐ In Person Pick-up at: _____
☐ CD	☐ Patient Portal	☐ Paper ☐ CD

Your Rights Regarding This Authorization: I may revoke this authorization at any time by providing written notice to the health information department. Any revocation will apply only to information that has not yet been released. I have the right to inspect and receive a copy of this authorization. Refusing to sign this form will not affect my ability to receive treatment, payment, health plan enrollment, or eligibility for benefits. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal and state privacy laws. This is a full release, including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

Expiration: This authorization expires one year from the date of my signature unless otherwise written here: _____

Signature: _____   Print Name: _____   Date: _____

Relationship to Patient: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign; however, supporting documentation may be required. **Minor Authorization:** If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

Signature of Minor: _____   Print Name: _____   Date: _____

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**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION**
(Authorization to Release Protected Health Information)

S300503 (Rev. 11/25)