



**ILLINOIS BONE and JOINT INSTITUTE, LLC**

**Lake Shore Orthopaedics**

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**PLEASE PRINT**

Authorization to Disclose/Release Protected Health Information

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

I authorize Illinois Bone and Joint Institute, LLC-Gurnee, Lake Shore Orthopaedics Medical Records Department to use/disclose a copy of the specified protected health information as indicated below to (recipient):

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Purpose or need for information:** \_\_\_\_\_

I authorize the use/disclosure of the following protected health information from (dates) \_\_\_\_\_ to \_\_\_\_\_

NOTE: \*Federal regulations require a description of how much and what kind of information is to be disclosed

- Send the entire medical record (all information) to the above named recipient.
- Send only the following information to the above named recipient: \_\_\_\_\_

\*The following items must be initialed to be excluded from the use/disclosure of protected health information:

- |   |  |
|---|--|
| <input type="checkbox"/> HIV/AIDS related information/records | <input type="checkbox"/> Genetic testing information/records           |
| <input type="checkbox"/> Mental health information/records    | <input type="checkbox"/> Drug/alcohol diagnosis, treatment or referral |

I understand that if the person or entity that receives the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal will in no way affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken in reliance upon this authorization. Unless revoked earlier, this authorization:

- is a 1-time request
- expires in 30 days
- expires in \_\_\_\_\_ days.

Signature of Patient or Patient’s Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Legal Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_