ILLINOIS CANCERCARE
Specializing in Cancer and Blood Disorders

Authorization Form For Release of Confidential Health Information

I hereby authorize Illinois CancerCare, P.C. ("ILCC") to release to:

_____

information contained in the patient record of _____ Date of Birth_____

The following information may be released:

_____

By initialing any of the lines below, I am specifically authorizing ILCC to use and/or disclose the category of confidential Information indicated next to the line, if applicable to this authorization.

_____ **Genetic Testing (ex: BRCA, PTEN, MSH2, etc)**

_____ **Alcoholism Treatment Records**

_____ **Drug Abuse Treatment Records**

_____ **Mental Health Treatment Records**

_____ **HIV/Acquired Immune Deficiency Syndrome (AIDS) Records**

The above information for the following period of time shall be released:

From _____ to _____

PURPOSE OF DISCLOSURE: _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that ILCC may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to ILCC of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where ILCC has already relied on it to use or disclose my health information. Written revocation must be sent to ILCC at the following address: **8940 N Wood Sage Rd, Peoria, IL 61615, Attn: Christy Kurland.**

Absent such written revocation, this *Authorization for Release of Confidential Heath Information* will terminate twelve months from the date below.

Signed:_____Dated:_____

If you are not the patient, please state the basis for your authority to act on behalf of the patient:_____

Representative Name: _____

Representative Address:_____

Representative Phone / Email:_____

NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION: No records or information from such records which are within the provisions of (1) the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (2) the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, (3) the Illinois AIDS Confidentiality Act, (4) the Illinois Genetic Confidentiality Act, or (5) other similar laws, may be further disclosed unless the person who executed the Authorization specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information is not sufficient for this purpose.