

# AUTHORIZATION FOR RELEASE 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. The federal rules bar any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient unless certain conditions are met.***

\_\_\_\_\_ Genetic Testing (ex: BRCA, PTEN, MSH2, etc.)

\_\_\_\_\_ Sexually Transmitted Diseases

\_\_\_\_\_ HIV / Acquired Immune Deficiency Syndrome (AIDS) Records

\_\_\_\_\_ Mental Health Treatment 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 Health Information will terminate twelve months from the date below.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***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:** \_\_\_\_\_