Family Planning Associates Medical Group, Ltd. / Albany Medical-Surgical Center

HIPAA Privacy Authorization Form

Standard Authorization to Use or Disclose Protected Health Information

1. **Individual** [Name and personal information of the person whose protected health information (PHI) is being disclosed]:

_____ _____

Name Date of Birth

_____

Address City State Zip Code

_____ _____

Telephone Number(s) Social Security Number

I was a patient at: □ 5086 North Elston Avenue, Chicago, IL 60630
□ 659 West Washington Boulevard, Chicago, IL 60661
□ 7845 South Cottage Grove Avenue, Chicago, IL 60619

2. **Authorization and Purpose:**

I request and authorize Family Planning Associates Medical Group, Ltd/Albany Medical Surgical Center to discuss, disclose and/or release my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal regulations.** With this in mind, please release my protected health information (medical records) to:

□ Myself □ My Primary Care Doctor □ My School or Employer □ _____

_____ _____

Person/Organization authorized to receive your health information Purpose

_____ _____ _____

Address City State Zip Code Fax Number Telephone Number

3. **Specific Description of Information to be Used or Disclosed:**

□ **I am ONLY requesting a COPY of my ultrasound, to be taken with me today (you may skip to the back side and sign).**

_____ I hereby authorize the **release of my COMPLETE HEALTH RECORD** (including records relating to mental health
(Initials) care, communicable diseases, HIV/AIDS, and/or the treatment of alcohol/drug abuse).

_____ I hereby authorize the release of my COMPLETE HEALTH RECORD with the exception of the following information: □ Mental Health Records □ Communicable Diseases (including HIV/AIDS)
□ Alcohol/Drug Abuse Treatment □ Other (please specify):_____

I authorize the release of my health records from all past present and future periods. _____
(Initials)

OR

I authorize the release of my health records from: _____ to _____. _____
(Initials)

4. **Expiration and Revocation:**

This authorization will expire on: □ One year from the date it is signed

□ Other (insert date/event):_____

5. **In signing this authorization, I understand and acknowledge the following:**

_____ This authorization is being made at my request, it is voluntary and I may refuse to sign it.
(Initials)

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
(Initials)

_____ I understand that I may revoke this authorization at any time by providing written notice to FPAMG/Albany Medical Surgical Center, stating my intent to revoke this authorization. I further understand that revocation of this authorization will not affect any action that this facility has already taken in reliance on this authorization before they received my revocation.
(Initials)

6. Signature/Verification of Identity

_____ _____
Patient Signature Date

If you are signing as Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the required Legal documents.

_____ _____
Personal Representative's Name Relationship to Patient

_____ _____
Address City State Zip Code Telephone Number

_____ _____
Personal Representative's Signature Date

FOR STAFF USE ONLY
_____ I have verified the identity of this patient with Picture Identification. (Staff Initial)
_____ _____ Staff Witness Signature Date
□ Records provided to the patient in person. Date:_____ □ Records sent via Fax, per patient request (noted avove). Date:_____ □ Records sent via United States Postal System, per patient request (noted above). Date:_____
Notes:_____

_____
