Family Planning Associates Medical Group, LTD

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: ❒ 659 West Washington Boulevard, Chicago, IL 60661
❒ 7845 South Cottage Grove Avenue, Chicago, IL 60619
❒ 4341 North Milwaukee Avenue, Chicago, IL 60641

2. **Authorization and Purpose:**

I request and authorize Family Planning Associates Medical Group, LTD 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
(Initials) payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by providing written notice to FPAMG, stating
(Initials) 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.

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 above). Date:_____

❒ Records sent via United States Postal System, per patient request (noted above). Date:_____

Notes:_____

_____