REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

Today's Date: _____

Patient Last Name	Patient First Name	Patient Middle Name
Patient Maiden Name / Alias / AKA	**Birth Date (MM/DD/YYYY)**	**Social Security #**
Address	**City**	**State / ZIP**
Phone Number	**Cell Phone Number**	**Work Phone Number**

INFORMATION REQUESTED. I authorize Aunt Martha's Youth Service Center, Inc. (AMYSC) to use or disclose the following information during the term of this Authorization. **Check all that apply.**

- ☐ Immunization Records
- ☐ School Physical
- ☐ Clinic Visit Notes
- ☐ Dental records
- ☐ Emergency Room Report
- ☐ Surgical (operative report, pathology report)
- ☐ Pharmacy Records
- ☐ Abstract Medical Record with diagnostic testing (Physician notes, diagnostic testing)
- ☐ Abstract Medical Record (Physician notes)
- ☐ Complete Medical Record
- ☐ Billing Records
- ☐ Therapy Notes (Please specify)

_____

- ☐ Diagnostic Testing (Please specify)

_____

- ☐ Other: _____

For the following dates of treatment: ☐ Specific date: _____ ☐ All dates

FROM THE FOLLOWING LOCATION:

☐ _____

- ☐ Aurora (101 S. Broadway, Aurora)
- ☐ Aurora HOC (680 S. River Street, Aurora)
- ☐ ***Aurora Satellite** (317 E. Indian Trial, Aurora)**
- ☐ ***Calumet City** (602 Torrence Ave, Calumet City)**
- ☐ Carpentersville (3003 Wakefield Drive, Carpentersville)
- ☐ Chicago Heights CHC (1536 Vincennes Ave, Chicago Heights)
- ☐ Chicago Heights PEDS (500 Dixie Hwy, Chicago Heights)
- ☐ Children's Reception Center (5001 S. Michigan Ave, Chicago)

***not an active site**

- ☐ Danville Center for Children's Services (702 N. Logan Street, Danville)
- ☐ Danville (614 N. Gilbert Street, Danville)
- ☐ ***Harvey** (159 E. 154th Street, Harvey)**
- ☐ Hazel Crest (17850 S. Kedzie Ave, Hazel Crest)
- ☐ Joliet East (1200 Eagle Street, Joliet)
- ☐ Joliet West (333 N. Madison Street, Joliet)
- ☐ ***Joliet St. Francis (1301 Copperfield Ave, Joliet)**
- ☐ ***Joliet Ottawa Street** (311 N. Ottawa, Joliet)**

- ☐ Kankakee (1777 Court Street, Kankakee)
- ☐ Little City (1760 W. Algonquin Rd, Palatine)
- ☐ Roseland (200 E. 115 Street, Chicago)
- ☐ South Holland (52 W. 162nd Street, South Holland)
- ☐ Southeast Side (3528 E. 118th Street, Chicago)
- ☐ Toulon (120 E. Court Street, Toulon)
- ☐ Watseka (200 E. Walnut Street, Watseka)
- ☐ Women's Health Center (233 W. Joe Orr Rd, Chicago Heights)

RECIPIENT. Delivery details – to you or to the person/company (for example, insurance company, school, physician)

Delivery Method: ☐ Pick up in person ☐ U.S. Mail ☒ Electronic requests@recdep.com ☐ Other _____

Send To – Name		**Phone Number**	
Records Deposition Service		(248) 357-3330, F (248) 357-3337	
Address	City	State	ZIP
P.O. Box 5054	Southfield	MI	48086-5054

The purpose of the copy (disclosure) is: ☐ My personal use ☐ Sharing with a healthcare provider ☐ Insurance ☒ Legal ☐ Other:

TERM: Unless a box below is checked, this Authorization will expire when the request is fulfilled.

- ☐ From the date of this Authorization until: _____
- ☐ Until the following event occurs: _____
- ☐ Other (please specify): _____

NOTE: For mental health records, the term must be stated, you may not use "no expiration."

FOR OFFICE USE ONLY

- ☐ Paper chart only
- ☐ Paper + Electronic
- ☐ Electronic Only
- ☐ Purged

HEALTHPORT ☐ Released ☐ Rejected

Aunt Martha's ☐ Released ☐ Rejected

# of pages	Date	Method	Initials
		☐ Pick up ☐ Patient E-delivery ☐ Scanned	

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Patient Last Name	Patient First Name	Patient Middle Name

SPECIFIC CONSENT SECTION Please note if the below is not completed, this information will not be released.

Check any or all of the boxes below to authorize this information to be used or disclosed with your record.

Information about:

- ☐ A Mental Illness or Developmental Disability
- ☐ HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative)
- ☐ Communicable Diseases
- ☐ Sexually Transmitted Infections
- ☐ Substance (i.e. alcohol or drug) Abuse
- ☐ Abuse of an Adult with a Disability
- ☐ Sexual Assault
- ☐ Child Abuse and Neglect
- ☐ Genetic Testing
- ☐ Artificial Insemination
- ☐ Psychotherapy Notes (which are not part of the official medical record)
- ☐ **All of the above (By checking this box, I am indicating that I have reviewed the entire list above and authorize the use and disclosure of all related confidential information in the manner described in this Authorization.)**

I understand that I may revoke this authorization at any time by notifying AMYSC in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by AMYSC before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient AMYSC cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand that AMYSC may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that AMYSC will not provide such research-related treatment unless I provide this authorization.
I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize AMYSC to use or disclose my health information in the manner described in this Authorization.

I agree that a photocopy of this authorization is as valid as the original.

Signature of Patient	Date	
Signature of Parent / Guardian or Representative (Generally required if patient is under 18)	Date	Relationship to Patient
Signature of Witness	Date	

***CONSENT OF MINOR:** The minor's (ages 12-17) signature is required in order to release information concerning care for 1) Mental Health; 2) AIDS/STD/HIV; 3) Drug/Alcohol Abuse; 4) Family Planning

Signature:	Date