HIPAA Authorization form

Who can Discuss your Medical Information

Patient name:	Date of Birth:

ABOUT THIS FORM:

- Let those listed below have information about your medical care or payment verbally in person or via telephone, this form does **NOT** replace the Release of Information which allows for copies of medical records
- Informs those listed below or a disaster relief organization of your location, health, or death

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION

1. Name:		Relationship to you:	
Phone #:	Street Address:		
City:		State:	Zip Code:
2. Name:		Relationship to you:	
Phone #:	Street Address:		
City		State:	Zip Code:
3. Name:		Relationship to you:	
Phone #:	Street Address:		
City		State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Promise Healthcare to talk about my health information to the persons listed above. Again this form does **NOT** replace the Release of Information which allows for copies of medical records:

Mark All You Approve:

☐ All Information
☐ Billing Information ☐ Appointment Information ☐ Lab Results ☐ Testing Results
☐ Treatment(s) ☐ Dental Services
☐ Other:_____

Patient/Parent/Guardian Signature:	**Today's Date**

Your permission expires in one year unless cancelled in writing

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Patient Initial and Date Required for Each Item):
I understand that the records requested above may contain sensitive medical information that requires my specific consent in order to be discussed. I specifically authorize Promise Healthcare to talk about my health information

with the people listed above. Again this form does **NOT** replace the Release of Information Form which allows for copies of medical records:

☐ Mental/behavioral health	Initials:_____	Date:_____
☐ Alcohol/Drug abuse records	Initials:_____	Date:_____
☐ Genetics	Initials:_____	Date:_____
☐ Reproductive Care	Initials:_____	Date:_____
☐ HIV/AIDS/Sexually transmitted diseases	Initials:_____	Date:_____

Please note:
The following medical information of a Patient 12 – 17 years of age (Minor Patient) is restricted as follows:

Drug/alcohol use, Reproductive health, AIDS/HIV, or Birth Control/Sexually Transmitted Disease(s)/Sexual Assault, as well as any health information generated as a result of the Minor Patient's independent legally-authorized consent to treatment, requires the Minor Patient's signature to this discuss.

Mental health or developmental disabilities information is available after the Minor Patient's signature, provided the Minor Patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor Patient's parent or guardian.

If patient is a minor, (age 12-17) then Promise requires an adult witness to sign as well.

Patient/Parent/Guardian Signature:	Today's Date
Witness Signature:	Today's Date
Witness Name (Printed)	Witness contact information
Witness Relationship to Patient	
Your permission expires in one year unless cancelled in writing	

Please Fill out this form. It will tell us which family members and friends have your permission to have discuss your health information.