Location: ☐Highland ☐Bolingbrook ☐Elgin-Villa ☐Elgin-Wing ☐Indian
☐Bensenville ☐Carol Stream ☐Romeoville ☐Tomcat ☐Joliet

Patient ID: _____
(Office Use Only)

400 N Highland Ave (630) 978-2532 Tel
Aurora, IL 60506 (630) 482-8180 Fax
www.vnahealth.com

VNA Health Care

☐ Picked up ☐ Faxed ☐ Mailed

Patient Name	**Maiden Name**
Phone	**Date of Birth**
Street Address	**City, State & Zip Code**

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I, _____ hereby authorize **VNA Health Care** to
(Patient / Legal Representative Name)

☐ Release (written/oral/electronic) information ☐ To:
☐ Receive ☐ From:

Agency/Facility/Person: _____
Address: _____
City/State/Zip: _____
Phone/Fax Number: _____

Concerning the care of above patient from dates: _____ **to** _____
(Start date) (End Date)
OR ☐ **Any and All Dates**

These records are released for the purpose of (Check all that apply)

☐ Continued Care ☐ Attorney/Client Relationship ☐ Insurance ☐ At the request of the patient
☐ Other_____

INFORMATION TO BE RELEASED:

☐ Any and All Records ☐ Diagnostic Reports ☐ Itemized Bills ☐ Laboratory/Pathology Report
☐ Obstetrics/Gynecology ☐ Office Visit Notes ☐ Dental Records ☐ Hospice Medical Record
☐ Home Health Medical Record ☐ Consultation Reports ☐ Phone Notes ☐ Immunization Records
☐ Other_____

I must ***initial**** one or more of the following types of health information that I request be released to or received from the Agency/Facility/Person named above.

****_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse**

****_____ Lab, diagnosis, evaluation and or treatment records for Sexually Transmitted Disease (STDs).**

****_____ Records of any HIV testing (AIDs test) result, diagnosis and/or treatment**

****_____ Psychiatric, psychological, or counseling records or evaluation and/or treatment for mental, physical and/or emotional illness, including, but not limited to, narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, and treatment plans.**

Patient ID: _____
(Office Use Only)

Your Refusal to Sign this Authorization: The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

Oral Communications: I understand that this Authorization allows the Health Care Provider (and its employees) to discuss my individually identifiable health information described herein with the recipient of the information.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be Re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Illinois law. Illinois law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Illinois law. A general authorization for the release medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

Expiration: This Authorization will expire one (1) year after the date below, or sooner by choice, in which case this Authorization will expire on _____ (if applicable, insert date on the foregoing line. Note: You may not indicate that there is no expiration; for example, the words "does not expire" or "no expiration" or "none" are not acceptable). However, if the records to be used or disclosed pursuant to this Authorization concern psychiatric, psychological and/or mental health treatment, this Authorization will expire 90 days after the date below, or sooner by choice, in which case this Authorization will expire on _____ (If applicable, insert date on the foregoing line, Note: You may not indicate that there is no expiration; for example, the words "does not expire" or "no expiration" or "none" are not acceptable).

_____ _____

****SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE**** **DATE**

_____ _____

****WITNESS SIGNATURE**** **DATE**

Printed name of patient's representative, if applicable: _____
Relationship to patient:

☐ Parent ☐ *Legal Guardian ☐ *Other: _____
*Legal documentation of Representative's authority must accompany this Authorization.

_____ _____

****Signature for Pick Up by Patient or Designated Individual**** **DATE**

Allow approximately 30 Business Days to Honor All Requests
Standard Record Coping fees may apply
Per 735 ILCS 5/8-2006

Office Use Only Fee/Paid $ _____ /_____ Date Called _____ Date Sent _____

Completed by whom: _____ Pages _____