 *Release Of Information*



Health Center

Today's Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please release medical records from:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To:* Midwest Refuah Health Center 6374 N. Lincoln Ave, Chicago Il 60659 Ph: 872-270-5999, Fax: 888-720-2959

***Information to be Disclosed/Obtained***

|  |  |
| --- | --- |
| * Mental Illness or Developmental Disability * Psychotherapy * Psychiatry * Alcohol/ Substance Use * Abuse or neglect * Sexual assault * HIV/AIDS * Genetic testing * Psychological testing * Communicable disease * Phone communication | * Medical/Legal Abstract * History and physical * Lab Results * Outpatient report * Radiology or imaging report * Emergency room documentation * Complete medical record plus what is checked on left. * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I authorize Midwest Refuah to use or disclose my health information including highly confidential information as selected above, during the term of this authorization for the following specific purpose(s):

|  |  |
| --- | --- |
| * Continuity of Care * Personal Use * Attorney/ Legal Case | * Disability / Insurance Application or Claim * Specialist * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* I understand that I have the right to revoke this authorization at any time. I understand that if I wish to revoke this authorization, I must contact the Midwest Refuah Management Department to do so.
  + I understand that the revocation will not apply to information that has already been released in response to this authorization.
  + I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
* I understand that Midwest Refuah may, directly or indirectly, receive compensation from a third party in connection with the use and disclosure of my health information.
* I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that are disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Midwest Refuah Health Center to use or disclose my health information in the manner described above.

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*Patient, Parent or Legal Guardian (printed) Signature Date*

\*\*This authorization is effective for one year from the above signature date

Midwest Refuah Health Center – 6374 N Lincoln Ave – PH: (872) 270-5999 – Fax: (888) 720-2959 – Email: [info@midwestrefuah.org](mailto:info@midwestrefuah.org)

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