Promise
Healthcare

HIPAA Authorization Form

Who can discuss your Medical Information?

Patient Name:____ Date of Birth: _______________________

About this form:

- This form allows those listed below to have information about your medical care and/or payment either verbally in person or via telephone.
- This form allows Promise Healthcare to inform those listed below (or a disaster relief organization) of your location, health or death.
- This form does **NOT** replace the 'Release of Information' form which allows for copies of medical records.

□ I **do not** wish to authorize Promise Healthcare to discuss my medical information with anyone.

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:

APPROVED TYPES OF INFORMATION:			
□ All Information	□ Appointment Information	□ Lab Results	□ Testing Results
□ Billing Information	□ Treatments	□ Dental Services	□ Other:_______________ ____________________

By signing, I allow Promise Healthcare to talk about my (or my dependent's) health information to the person listed above. I understand that this form does NOT replace the 'Release of Information,' and does not allow those listed above to receive copies of my medical records.

Patient/Parent/Guardian Signature: ____ Date: _____________________

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HIPAA Authorization Form (cont.)

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Initial and Date Required for Each Item):

I understand that the information approved above may contain sensitive medical information that requires my specific consent in order to be discussed. By initialing each item, I specifically authorize Promise Healthcare to talk about the following sensitive topics with the people listed on this form:

- ☐ Mental/Behavioral Health — Initials: ________________ Date: ________________________
- ☐ Alcohole/Drug Abuse — 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, other sexually transmitted disease(s), birth control, 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 discuss.

Information in mental health or developmental disabilities will be 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) Promise Healthcare requires an adult to witness the signing.

Patient/Parent/Guardian Signature:	Today's Date:
Witness Signature:	Today's Date:
Witness Name (printed):	Witness phone #:
Witness Relationship to Patient:	

This authorization will be valid as long as the patient remains a patient of Promise Healthcare unless patient designates an expiration date or revokes the authorization in writing. If patient fills out multiple versions of this form, all previous versions of this form are void and only the newest form with the most recent date of signature is accepted. If the patient is a minor at time of signature, this authorization expires upon the minor's age of majority.