CommunityHealth

Authorization for Release of Protected Health Information

I, _____ _____ _____
Last Name First Name Middle Initial

Patient's Date of Birth _____/_____/_____

Hereby Authorize and Request

_____
Health Care Facility Name and Address

To provide **CommunityHealth** with records regarding the following information:

____Discharge Summary	___ Emergency Room Records
____ History and Physical	___ Laboratory Reports
____ Operative Report	___ EKG/EEG
____Progress Notes	___ X-Rays/Imaging
____Pathology Report	___Other (please specify)
	_____

Date(s) of Treatment (if known) _____

Please send records to:

CommunityHealth
2611 W. Chicago Avenue
Chicago, IL 60622
Phone number: (773) 395-9900
Fax number: (773) 395-9902

Authorization for Release of Sensitive Protected Health Information

This authorization is valid for one year. I understand that I may revoke this authorization in writing at any time, but not retroactive to the release of information made in good faith.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases)
- Drug, alcohol or substance abuse
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions)
- Genetic testing

☐ **Yes** ☐ **No**

_____ _____
Signature CH staff

Date: _____