CommunityHealth

Authorization for Release of Protected Health Information
Autorización para facilitar la información protegida de su salud

I, _____ _____ _____
Last Name/Apellido First Name/Nombre Middle Initial/ Inicial

Patient's Date of Birth/Fecha de Nacimiento: _____/_____/_____
Mes/día/ año

Hereby Authorizes and Requests/Por medio de la presente autorizo y solicito:

_____
Health Care Facility Name and Address/Nombre y direccion de la clinica o el hospital

To provide **CommunityHealth** with records regarding the following information/Proveer a **CommunityHealth** mi historial médico:

_____Discharge Summary/ Informe de alta hospitalario

_____ Emergency Room Records/ Historial de la sala de urgencia

_____ History and Physical / Historial y físico

____ Laboratory Reports /Informe de análisis

_____ Operative Report/Informe quirúrgico

____ EKG/EEG / Electrocardiograma

_____ Progress Notes/ Informe médico

____ X-Rays/ Radiografías

_____ Pathology Report
Informe de anatomía patológica

____Other (please specify below)
Otro (anotar abajo)

Fecha de tratamiento/procedimiento/Treatment Dates (si se conoce): _____

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

Authorization of Release for Sensitive Protected Health Information

Debe de anotar "Si o "No" Si autoriza el facilitar la siguiente información, aparte de la información mencionada arriba.
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/ Sí** ☐ **No**

_____ _____
Signature / Firma CH Staff signature/ Firma del Personal de Clínica

Date / Fecha: _____ / _____ / _____
Mes Día Año