LAWNDALE CHRISTIAN HEALTH CENTER
Loving God. Loving People.

Health Information Management Department
3860 W. Ogden Avenue, Chicago, IL 60623
Phone: 872-588-3120 Fax: 872-588-3131

Authorization to Release Health Information from Lawndale Christian Health Center

Patient Information

Name ______________________

Birthdate ______________________

Phone ______________________

❍ Release to patient as named above

I authorize Lawndale Christian Health Center to release information to:

Person / Institution ______________________

Address ______________________

City, State, Zip ______________________

Phone ______________________ Fax ______________________

Information to be Released

❍ Immunization/shot records ❍ School physical form ❍ Laboratory reports ❍ Billing records

❍ Complete medical record ❍ Prenatal records ❍ Radiology reports ❍ Other _______________

I specifically prohibit the release of the following sensitive health information. I understand that for any of the following boxes that are not checked, the health information released to the named recipient may include diagnosis, evaluation and/or treatment information for the following:

❍ HIV or AIDS testing information or results ❍ Alcohol and/or substance abuse ❍ Behavioral health

Dates of Service Requested

❍ Most Recent ❍ From ____________ to ____________ ❍ All

Reason for Release

❍ Patient request ❍ Continuity of Care/Other provider ❍ Other (specify) ______________________

Delivery Requested

❍ CD by mail ❍ Electronic by secure message (e-mail) ❍ Paper by mail

❍ CD for pickup ❍ Paper for pickup ❍ Paper by fax

Fees will be determined from the LCHC Fee Schedule, and requests requiring payment must be paid in advance by check or money order. You will be contacted by LCHC staff regarding the exact fee.

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Privacy Officer at this site of care, except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released. I understand that this authorization is voluntary and I may refuse to sign this authorization. The above named person/insitution will not refuse to treat me based on whether I allow my health information to be used and disclosed by others. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations. This authorization shall remain valid unless revoked but will expire 90 days from the date of my signature or as otherwise specified by the date, event or condition(s) as follows:____

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Parent/Legal Guardian or Representative Relationship to Patient
(Required if patient is not legally authorized to sign authorization)

______________________________ ______________________
Witness Signature Relationship to Patient

LCHC OFFICE USE ONLY

Chart number ______________ ❍ Identity Verified (by ID or signature) Receipt number ______________

❍ no charge (shot records or records sent to medical provider)

❍ $5 (school physical form only) Fee notification by (staff name) ____________ on (date) ____________

❍ Pages ____________ Fee ____________ PHI released by (staff name) ____________ on (date) ____________