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How to Complete Your Illinois HIPAA Authorization

Authorization for Release of Protected Health Information (45 C.F.R. 164.508 and Illinois law)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers can talk to about you. This authorization lets the people you name receive your health information so they can help you, even before they need to act as your agent.

1. **Your information (Page 1)**
   Enter your name, date of birth, and address.
2. **Who may receive it (Page 1)**
   Name each person who may receive your health information, such as your agents under your powers of attorney or family members.
3. **What and for how long (Pages 1–2)**
   Choose what may be released and when this authorization expires. Initial each type of specially protected record you want included.
4. **Sign before a notary (Page 2)**
   Illinois requires a witness who can confirm your identity before mental health records are released. The notary acknowledgment serves that purpose and makes hospitals and insurers far more likely to accept the form. Bring a current, government-issued photo ID.

After It's Signed

- Give copies to the people you named and to your doctors, hospitals, and health plans.
- You can revoke this authorization in writing at any time, except for information already released.
- This form works best alongside an Illinois Power of Attorney for Health Care. We have a free form.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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HIPAA AUTHORIZATION

Authorization for Release of Protected Health Information (45 C.F.R. 164.508)

1. PATIENT

Full legal name

Date of birth

Address (street, city, state, ZIP)

Telephone

2. WHO MAY RELEASE INFORMATION

I authorize every physician, hospital, clinic, laboratory, pharmacy, therapist, health plan, insurer, and other covered entity or health care provider that has provided treatment, services, or payment to me to release my protected health information to the persons named in Section 3.

3. WHO MAY RECEIVE INFORMATION

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

4. INFORMATION TO BE RELEASED (check one)

All of my health information, including medical records, test results, diagnoses, treatment, billing, and payment records.

Only the following:

Illinois and federal law give extra protection to certain records. Unless I initial below, this authorization does **not** include psychotherapy notes or the records listed. I separately authorize release of (initial each):

☐ Mental health and developmental disabilities records (other than psychotherapy notes)

☐ HIV/AIDS test results and related information

☐ Substance use disorder treatment records

☐ Genetic testing information

Patient's initials: _____

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5. PURPOSE

At my request, to allow the persons named to discuss my care with my providers, assist with my health care and insurance matters, and, if applicable, carry out their duties under any power of attorney or advance directive I have signed.

6. EXPIRATION (check one)

This authorization expires two years after my death.

This authorization expires on the following date or event:

Date or event

7. MY RIGHTS

- I may revoke this authorization at any time by giving written notice to the provider or plan holding my information, except to the extent action has already been taken in reliance on it.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules. Mental health, HIV, and substance use disorder records keep the extra protections that Illinois and federal law give them.
- I may inspect and copy any mental health information that is disclosed under this authorization.
- I am entitled to a copy of this authorization. A photocopy or electronic copy is as valid as the original. My agents under any health care power of attorney are to be treated as my personal representatives.

Date

X

Signature of patient (or personal representative)

Printed name

If signed by a personal representative, describe authority (e.g., agent under health care power of attorney, guardian)

NOTARY ACKNOWLEDGMENT (also serves as witness to identity)

STATE OF ILLINOIS)
COUNTY OF) SS.

This instrument was acknowledged before me on

(date)

by (name of signer)

X

Notary Public

(Notary seal)

Notary's printed name

My commission expires

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