LOYOLA MEDICINE
We also treat the human spirit.®

MOBILE MEDICAL UNIT CONSENT FOR RELEASE OF HEALTH INFORMATION

Child's Name (Please Print)	Phone	Date of Birth	SSN (Last 4 digits) XXX-XX - __ __ __ __
Address	City	State	ZIP

The undersigned hereby authorizes and requests Loyola University Medical Center and Staff of the Ronald McDonald Children's Hospital to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to:

Name (Please Print)		Phone	
Address	City	State	ZIP

Dates of treatment/service to be released: _____

Location of treatment: _____ Mobile Medical Unit: _____

Purpose for which this information is to be released:_____

INFORMATION TO BE RELEASED (Check all that apply)

□ Physical Examination Records □ Immunization Record □ Other (Specify) _____
□ Health Screening Records □ Lab Results

SECTION A: If your health information contains *any of the following*, please check all categories that apply in order to avoid delay. By checking any of these categories, you are authorizing the release of the following information:

□ Psychiatric/mental health or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)

□ HIV test results □ AIDS/related illness, diagnosis/treatment □ Genetic testing □ Alcohol/drug abuse diagnosis/treatment

You must acknowledge that you are checking these categories by furnishing your written signature below:

_____
Signature

SECTION B: This consent for release of information is valid until ___/___/___ (You must specify the month, date and year or we cannot process this request). You have the right to revoke this authorization except that such revocation will not apply to any uses and disclosures of your information that are described in the LUHS Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.

I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have read, or had explained to me, the information contained in the above Consent for Release of Information and I confirm that the contents are consistent with my direction to you. I have had a chance to ask questions which were answered to my satisfaction, and I understand the Consent for Release of Information. I also understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form.

To revoke this information, write to the Director of Medical Records, Loyola University Health System, 2160 S. First Avenue, Maywood, Illinois, 60153. Include a copy of this authorization with your correspondence.

NOTE: WE CANNOT CONDITION TREATMENT BASED ON YOUR SIGNING OF THIS AUTHORIZATION

Representative Signature: _____ **Date:** _____

Relationship to Child: □ Mother □ Father □ Legal Guardian

Prohibition on Redisclosure (if applicable)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by the facility releasing medical records pursuant to the authorization may not be further disclosed.