TAB 36
Authorization of DePaul to Use and Disclose Protected Health Information

See attached

AUTHORIZATION OF DEPAUL FAMILY AND COMMUNITY SERVICES TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ____

Last **First** **Middle**

Home Address: ____

____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: ____

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MY HIGHLY CONFIDENTIAL INFORMATION:
Without limiting the information specified above, by checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize DePaul Family and Community Services ("FCS") to use and disclose the category of highly confidential information (indicated next to the box) about me, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or developmental disability services
- ☐ Alcohol/drug abuse treatment program records and information
- ☐ HIV/AIDS test results
- ☐ Other: ____

I understand that I have the right to inspect and copy the information to be disclosed.

RECIPIENT: Name of person or agency to whom FCS may disclose my health information:

____

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____

Address of the recipient or where my health information should be delivered: ____________

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TERM: This Authorization will remain in effect from the date of this Authorization until ____________ __, 20__

PURPOSE: I authorize FCS to use or disclose my health information (including My Highly Confidential Information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

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____

I understand that once FCS discloses my health information to the recipient, FCS cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes records or information about mental health or developmental disability services that you received from FCS, the confidentiality of the records or information is protected from redisclosure by the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at FCS; except, however, if my treatment at FCS is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case FCS may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to FCS at the address listed below. The revocation will be effective immediately upon the FCS's receipt of my written notice, except that the revocation will not have any effect on any action taken by FCS in reliance on this Authorization before it received my written notice of revocation.

I may contact the FCS Business Manager by mail at 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by telephone at (773)325-7788 or by email at DePaulFCS@depaul.edu with any questions about this Authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize FCS to use or disclose my health information in the manner described above.

________________________	__________________
Signature of Patient **(Patient is at least 12 years old)**	**Date of Signature**
Signature of Witness	**Date of Signature**

INSTRUCTION: If the patient is a minor under the age of 12 or is otherwise unable to sign this Authorization, obtain the following signature *in addition to the Witness signature*:

____________________	____________	____________
Signature of Parent or Other Authorized Personal Representative	Relationship to Patient	Date

________________________ ______________________

Printed Name of Personal Representative | Date of Signature

FOR FCS ADMINISTRATIVE PURPOSES: Include a copy of this Authorization in the patient's medical record in Tier.