Advocate Health Care | Aurora Health Care

Now part of ADVOCATEHEALTH

MRN: ______________________________

1) **PATIENT INFORMATION:**

Name ______ Address ______ City ______ State ______ Zip ______

Date of Birth ______ ( ) Daytime Phone ______ Previous Name ______

2) **AUTHORIZES:**

Name of Health Care Provider/Plan/Other ______ Address ______

3) **TO DISCLOSE TO:**

☐ Myself (*select delivery option below)*
- ☐ LiveWell/MyAdvocateAurora portal ☐ View on Site
- ☐ Mail to my address above ☐ Pick up

If Mail or Pick up:

☐ Paper or ☐ Electronic format: ______________________

☐ If to be picked up by another, I hereby authorize ____________________ to pick up my records. (Photo ID required)

☐ Send to third party: ______________________

Attn: ______________________

Address: ______________________or

Fax: ______________________

Third Party Phone #: ______________________

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From__________________ (month/year) to ________________ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

5) **INFORMATION TO BE DISCLOSED:**

☐ Pre-Employment ☐ Physical Exam Records ☐ Immunization Records ☐ TB Skin Test Results ☐ Fit Test

☐ Lab Reports ☐ Imaging Reports ☐ Client Service Abstract (see back page) ☐ Other: ____________________

6) I understand that the information to be disclosed may include information regarding genetic testing, mental health developmental diabilities. Substance Use Disorder, HIV Test results, and AIDS/AIDS-related illness. We will release this information unless you indicate which information should be excluded below.

☐ Substance Use Disorder ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

☐ Genetic Testing ☐ AIDS/AIDS-Related Illnesses

7) **PURPOSE OF DISCLOSURE:** ☐ Employment Requirements ☐ School ☐ Further Medical Care ☐ Insurance ☐ Disability Determination ☐ Legal ☐ Personal Use ☐ Other: ____________________________

8) **EXPIRATION:** This Authorization is good for: ☐ 1 month ☐ 6 months ☐ 1 year Other date or event: ____________________

If no date or event is specified, this Authorization will expire one (1) year from the date signed. **IL Only:** Mental health/developmental disability records/information may be released only on the day the authorization is received.

9) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization. I understand that I may be charged a fee for record copies. I understand that I may revoke this Authorization by notifying the health information department in writing. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Advocate Aurora Health (AAH). I understand that this is an evaluation and that my participation does not imply a Doctor/Patient relationship with the examining medical provider. I also understand that the occupational health services received from AAH are provided for the purpose of disclosing the results to my employer or other third party. Refusal to sign this Authorization may result in a refusal by AAH to provide me with the specific occupational health services that have been requested.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes. I am aware that both Occupational and Teammate Health records may be disclosed.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE ______ **DATE** ______

If signed by a person other than the patient, complete the following: Individual is: ☐ **Legal authority** ☐ **Legal guardian**

10) In the event additional information is needed, I further authorize AAH Occupational Health (AAH OH) to access my AAH and my other health care provider's treatment information for assessment and employment requirements. I am aware that any information created, collected, and/or maintained by AAH and its affiliated hospitals, clinics, labs, pharmacies, etc. may be included in my AAH record. Further, I understand that my AAH record and other health care provider's records may include, if applicable, HIV/AIDS test results, behavioral health records, substance use disorder records. I am aware AAH OH will have access to all existing information in my records and future information not yet created until the expiration date of this Authorization.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE ______ **DATE** ______

11) **IL Only** - witness signature for mental health/developmental disabilities records only: ______________________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (OCCUPATIONAL HEALTH AND TEAMMATE HEALTH)

(HIM ROI Authorization)

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PATIENT AUTHORIZATION REFERENCE GUIDE

Health Information to be Disclosed to your Employer may include the following:

CLIENT SERVICE ABSTRACT may include records related to the following, if these services were provided by Advocate Aurora Health Occupational Health:

- Progress notes, medical history, consultations, radiology reports, EKG, pathology reports, procedure reports, medication list, therapy evaluations and notes
- Results of physicals and any information provided in conjunction with a physical
- Drug tests
- Breath, blood, saliva, or urine alcohol tests
- Spirometry tests
- Respiratory fitness tests
- Immunizations and vaccinations; may include previous immunizations records from Immunization Registry or supplied by the patient
- Audiometric tests
- Lab results may include lab results supplied by the patient
- Other screenings performed for the purpose of determining employment or related to workplace surveillance