AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
FAMILY MEMBER FMLA DISCLOSURES

If the information sought is about a Mental Illness or Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Diseases, Venereal Disease(s), Substance (i.e., alcohol or drug) Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse and Neglect, or Genetic Testing, then the patient must sign the Specific Consent Attachment.

A patient label may be placed here:

Patient's Name: _____
Last First Middle
Medical Record Number: _____
Home Address: _____
_____
Home Telephone: _____ **Date of Birth:** _____

The UC Organized Health Care Arrangement (or **UC OHCA**) consists of University of Chicago HMedical Center (UCMC) and certain activities of the University of Chicago including the physicians.

Each of these is called a **UC Organization**.

PURPOSE: My family member, _____ (*insert name*), who is my _____ (*describe the family relationship*) is seeking Family and Medical Leave Act leave ("**FMLA**") and his/her employer has asked that UCMC complete an FMLA form. I authorize UCMC to complete the FMLA form and give it to my family member or send it to his/her employer.

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes (*describe each type of information requested on the form, such as "diagnosis" or "treatment period."* _____

_____.

EMPLOYER RECIPIENT: The following is the name of the person or the class of persons to whom UCMC will disclose my health information and the address where the completed FMLA form will be sent (*you may attach the FMLA form if it contains the name and address of where we are sending the information*): _____

_____.

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the following date: _____, 20 __.
☐ Until purpose is fulfilled.
☐ Until the following event occurs (e.g. after the specific fundraising program is over):

_____.
☐ Other (e.g. no expiration): _____.
Note: The Term for mental health records must be stated—you may not use "no expiration."

***Provide a copy of signed Authorization to Patient**

I understand that once my health information is disclosed to the recipient, neither UCMC nor any of the other UC Organizations can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy any information used/disclosed under this authorization.

I understand that UC Organizations will not, directly or indirectly, receive any items of value from any third party in connection with the use or disclosure of the health information.

I understand that I may change my mind and revoke this authorization in writing at any time by notifying the Privacy Office (see the information below), and changing my mind will not affect my treatment. The revocation will not apply to the extent that any UC Organization has already taken action where it relied on my permission.

I have read and u nderstand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize each UC Organization to use or disclose my health information in the manner described above.

_____ _____

*Signature of Patient or Personal Representative** *Date*

_____ _____

Name of Personal Representative (if applicable)* *Relationship to Patient*

** The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

Privacy Office: University of Chicago Medical Center, MC-1000, 5841 South Maryland Avenue, Chicago, IL 60637, Telephone Number: (773) 834-9716

Last Updated January 7, 2010

***Provide a copy of signed Authorization to Patient**

SPECIFIC CONSENT ATTACHMENT

Patient's Name: _____
Last First Middle

Medical Record Number: _____

SPECIFIC CONSENT

By checking any of the boxes next to a category of confidential information listed below, I specifically authorize the use and/or disclosure of the category of confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about a Mental Illness or Developmental Disability

☐ Psychotherapy Notes (which are not part of the official medical record)

☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

☐ Information about Communicable Diseases

☐ Information about Venereal Disease(s)

☐ Information about Substance (i.e., alcohol or drug) Abuse

☐ Information about Abuse of an Adult with a Disability

☐ Information about Sexual Assault

☐ Information about Child Abuse and Neglect

☐ Information about Genetic Testing

I have read and understand the terms of this Attachment and I have had a chance to ask questions about the use and disclosure of the confidential information. I authorize each UC Organization to use or disclose the confidential information checked above in the manner described above.

_____ _____
Signature of Patient or Personal Representative *Date*

_____ _____
Name of Personal Representative (if applicable)* *Relationship to Patient*

Witness' Signature required for release of information about a mental illness or developmental disability

Signature of Witness:_____

***Provide a copy of signed Authorization to Patient**