THE UNIVERSITY OF CHICAGO | Human Resources

Questions about thisform? Contact HR Benefits
E-mail: benefits@uchicago.edu

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my medical, behavioral, and mental health information (also known as protected health information (PHI)) as described below.

1. I, ______________________________, authorize all persons or entities who provided medical treatment to me to disclose the all medical information in your possession to CCMSI, its employees, agents, subcontractors and authorized representatives ("CCMSI") as specified below.

2. Please provide CCMSI with any and all information in your possession concerning my physical condition, past, present and future, including, but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other PHI/medical information so that CCMSI may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on ___________. I understand that the PHI/medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This authorization shall be in force and effect until my claim related to injuries I received on _____________ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying **Human Resources, Absence Management Coordinator** **OR** ***CCMSI, 910 W. Van Buren Street, #406; Chicago, IL 60607*** in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by CCMSI or the Releasing Party in reliance on it before I revoked it.

4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to CCMSI to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

5. A copy of this authorization may be accepted with the same authority as the original.

6. I understand that I have a right to receive a copy of this authorization form after I sign it.

____________________________________	__________________
Signature of Patient or Personal Representative	Date
____________________________________	__________________________
Print Name of Patient or Personal Representative	Personal Representative's Authority
____________________________________	______________________________
Witness Name	Witness Signature