# Fox Valley Medicine, Ltd.

*A Personal Touch to Healthcare®*

P.O. Box 8200 ❖ Westchester, Illinois 60154
630.482.9758 ❖ 312.283.3546 (fax)

## AUTHORIZATION FORM
## FOR USES AND DISCLOSURES OF PROTECTED PATIENT HEALTH INFORMATION

**Patient Name:** ______________________ **Date of Birth:** ____________ **ID #:** ____________

Please complete this form in its entirety. Please designate below the person you are giving authorization to discuss your protected health information. Their name, address, phone number and your relationship with them is required. Please feel free to contact a Member Advocate directly at 630-482-9758 should you need assistance in completing this form.

I hereby voluntarily request and authorize Fox Valley Medicine, Ltd. personnel to release and/or discuss protected health information with the following person(s):

**Name:** ______________________________ **Phone Number:** ______________

**Address:** ______________________________ **Relationship:** ______________

### Requested Information

I authorize the following types of protected health information to be used and disclosed:

❑ Authorizations ❑ Benefit Inquiries ❑ Claims ❑ Concerns

### Purpose of the Request Use or Disclosure is:

❑ At the request of the patient
❑ Other (indicate specific reason) ______________________________

### Expiration Date: This authorization will automatically expire

❑ 12 months from the date of the signature below
❑ When the following event occurs (specify) ______________________________

### Please note the following

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. Your refusal will not affect your ability to obtain treatment, enrollment, and eligibility for benefits or payment.**

1. If the person(s) or entity(s) that are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may redisclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to: Fox Valley Medicine, Ltd., Privacy Official, 37W002 Mooseheart Road, Suite 100, Mooseheart, Illinois 60539.
3. The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health information.

I ______________________ have had full opportunity to read and consider the contents of this authorization and confirm the directions I have given you. By signing this I confirm that you may use or disclose to the person(s) named above the protected health information described in this form.

**Signature:** ______________________________ **Date:** ______________
Patient/Legal Representative

**You are entitled to a copy of this authorization after you sign it.**