



# Authorization for Use or Disclosure of Information

## Lake Forest Hospital

660 N. Westmoreland Road  
Lake Forest, Illinois 60045-1696  
(847) 234-5600

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient Name (Printed):**

Persons/Organizations authorized to **provide** the information:  
(Name, address, facsimile number)

---

---

---

---

**Date Of Birth:**

Persons/Organizations authorized to **receive** the information:  
(Name, address, facsimile number)

---

---

---

---

(Additional space on reverse side of this form)

**Specific description of information** (including dates):

---

---

Please check any of the following types of information included in the records being disclosed:

- Mental health information and developmental disability
- Alcohol/Drug information
- HIV/AIDS test results
- Genetic test results or information

Brief description of information

If you checked any of the boxes above, **a witness must sign and date this authorization:**

Signature of witness attesting to identity of authorizing person

Date

Printed name of witness

**What is the purpose of the requested use or disclosure?**



# Authorization for Use or Disclosure of Information

## Lake Forest Hospital

660 N. Westmoreland Road  
Lake Forest, Illinois 60045-1696  
(847) 234-5600

**I understand that:**

- Neither my health care nor payment for my health care will be affected if I do not sign this form; except for health care related to employment physicals, injuries or illnesses sustained on the job, and research.
- I have the right to inspect and receive copies of the information to be disclosed as described in the Lake Forest Hospital Notice of Privacy Practices.
- This authorization will expire 90 days after signing.
- I may revoke this authorization at any time by notifying Lake Forest Hospital in writing, as explained in the Lake Forest Hospital Notice of Privacy Practices. If I revoke this authorization, it will not have any effect on any actions Lake Forest Hospital may have taken before it received the revocation.

\_\_\_\_\_  
Signature of patient or patient's representative  
*(Form must be completed before signing)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative if applicable

\_\_\_\_\_  
Relationship to patient

Additional persons/organizations authorized to receive the information (name, address, facsimile number):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**For Facility Use Only**

Request: (please check)  Completed  Not completed

\_\_\_\_\_  
Patient's Medical Record #