AUTHORIZATION FOR RELEASE OF NURSING HOME RECORDS

I _____ authorize
(Name of nursing home resident)

_____ to examine all records of my care at
(Name of person looking at the records)

_____ Nursing Home, whenever (s)he so requests.
(Name of nursing home)

The purpose of this request is: at the request of the individual.

I authorize this person to receive a copy all records of my care. Circle one**: YES NO**

I instruct the Nursing Home to give this person any information (s)he requests about my health and my health care, whenever (s)he asks. Circle one: **YES NO**

The information released to this person shall include information, if any, about my mental health status and treatment. Circle one**: YES NO**

The information released to this person shall include information, if any, about my substance use and substance use treatment. Circle one**: YES NO**

The information released to this person shall include information, if any, about my HIV status and treatment. Circle one**: YES NO**

I understand that, once this information is released, it is no longer protected by HIPAA.

I understand that I can revoke this authorization at any time by telling the administrator or the Director of Nursing, in writing, that it has been revoked.

This authorization expires when nullified by a court of competent jurisdiction.

Signed _____ Date: _____
(Signature of nursing home resident)

INSTRUCTIONS

Fill in the resident's name, the nursing home, the person who gets to see or copy the records, and the date. To let this person get a copy of the records, get information about particular health issues, or keep getting information about the resident's health and health care, circle **YES** up above on the form.

The resident must sign the form for it to take effect.

For help in seeing or copying nursing home records, call the Chicago Department of Family and Support Services nursing home resident ombudsman at **312-744-4016.**