HCCI
HOME CENTERED CARE INSTITUTE

Patient Communication Choices Authorization: Family and Friends Involved in my Care

By signing this authorization form, you are allowing _____ (organization name) to share your health information with the family and friends listed below and those who may be involved in your care or payment for care.

Full Name	Relationship to Patient	Contact Number	Authorization to leave voicemail
			O Yes O No
			O Yes O No
			O Yes O No
			O Yes O No
			O Yes O No

I give permission for _____(organization name) to share, either verbally, in writing, by phone or through voicemail, my health information to the following individuals for purposes of my care and/or payment for care. I understand that my health information may include (if applicable to me) the following types of information:

- HIV/AIDS
- Behavioral or mental health
- Developmental disabilities
- Genetic testing and counseling
- Artificial insemination
- Sexual assault/abuse
- Domestic abuse of an adult with a disability
- Child abuse and neglect
- Treatment for substance (alcohol and/or drugs) use disorder
- If I am a minor, sexually transmitted illnesses, pregnancy and birth control

I understand that I have the right to withdraw this authorization at any time and my withdrawal must be in writing. Any withdrawal will not apply to information already released by the organization named above prior to my withdrawal. For information on how to withdraw this authorization, contact the office, compliance, or health information management department. If not withdrawn, this authorization is valid until I or my personal representative revokes this authorization in writing. I understand this means this authorization does not expire.

Additional notices required by law:

- ☐ I understand that, once the family member or friend authorized to receive my health information has received it, the information may no longer be protected by federal privacy laws, and that person may be able to further disclose or share my health information. However, Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health or developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR.

- ☐ I understand that I am not required to complete this authorization form. If I choose not to complete this form, _____ (organization) will still care for me.

- ☐ I understand I have the right to inspect and copy the mental health and developmental disabilities records to be released.

_____ _____

Patient Name and Signature *(for patients age 12 and older)* Date

_____ _____

Parent/Guardian/Legal Representative Name and Signature Date

_____ _____

Witness Name and Signature Date