



## RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_  
Last First MI

MRN: \_\_\_\_\_

Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Phone: \_\_\_\_\_

I authorize Tapestry 360 Health to release medical records (which may be copied, orally communicated, or faxed) from *my* record as stated below

Information to be released FROM:	Information to be released TO:
<p style="text-align: center;">Tapestry 360 Health Medical Records Office 845 W Wilson Ave Chicago, IL 60640</p> <p>Phone: 872-260-3852 Fax : 773-437-6812</p>	
	Organization/Person Name
	Street Address
	City, State, Zip
	Phone: Fax:

**Sensitive Information** (Initial below if you do NOT want the following info to be disclosed):

\_\_\_ HIV/AIDS \_\_\_ Mental Health \_\_\_ Alcohol/Substance Use \_\_\_ Genetic Testing

For the following dates of treatment: -- to \_\_\_\_/\_\_\_\_/\_\_\_\_ (If blank, we will release records from the past 12 months)

Type of information (entire record will be released unless specified) \_\_\_\_\_

Purpose of Disclosure: ☐ Transfer of care to another provider ☐ Referral/Consultation ☐ Insurance claim  
☐ Personal use ☐ Disability determination ☐ Other:

This authorization is valid until \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date not to exceed 1 year)

I acknowledge that I have fully reviewed and understand the contents of this form. I acknowledge that a photocopy or fax of this form is valid. I understand that

I have the right to inspect and receive a copy of the information to be disclosed.

I understand that I may refuse to consent to the release of the above information and that I may revoke this authorization at any time except to the extent action has already been taken.

I understand that my consent is voluntary; however, my refusal may hamper further evaluation or treatment.

I understand that if the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws.

I understand that if the patient is 12-17 years old, the patient must sign this consent in order to disclose certain protected information, pursuant to the Consent by Minors to Medical Procedures Act and the Mental Health and Developmental Disabilities Confidentiality Act

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Minor if Patient is 12-17 years old

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Not Patient, then Name and relationship to Patient (for example: Parent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Tapestry 360 Health Staff Member

\_\_\_\_\_  
Date