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AUTHORIZATION FOR THE RELEASE OF INFORMATION

PATIENT NAME:_____ DATE OF BIRTH_____

(PLEASE PRINT)

REQUESTED INFORMATION DATES (S) OF SERVICE/TREATMENT_____

(BELOW PLEASE PRINT THE INDIVIDUAL AND/OR AGENCY/ORGANIZATION TO WHOM DISCLOSURE IS TO BE MADE)

SEND TO:_____ Date of Request _ _____

ADDRESS:_____ PHONE # ( ) _____

_____ FAX # ( ) _____

YOU ARE HEREBY AUTHORIZED TO RELEASE CORRESPONDING MEDICAL RECORD INFORMATION

TYPE OF MEDICAL RECORD INFORMATION TO BE DISCLOSED (CHECK BOX)

- ❑ Physician/Nurse Notes
- ❑ Laboratory Reports
- ❑ Ultra Sound
- ❑ Pap Smear
- ❑ Prenatal Records
- ❑ All
- ❑ Other (Please Specify) _____

PURPOSE OF DISCLOSURE (CHECK BOX)

- ❑ **CONTINUING MEDICAL CARE**
- ❑ **LEGAL**
- ❑ **PREGNANCY (Dates _____)**
- ❑ **INSURANCE**
- ❑ **OTHER**
- ❑ **SURGERY (Dates) _____)**

(PLEASE SPECIFY/)_____

LIMIT/EXCLUSIONS

THIS RELEASE OF INFORMATION MAY CONTAIN HIGHLY SENSITIVE INFORMATION RELATED TO THE TESTING DIAGNOSIS AND/OR TREATMENT OF THE FOLLOWING:

- ❑ MENTAL HEALTH
- ❑ ALCOHOL AND/OR SUBSTANCE ABUSE
- ❑ HIV/AIDS, SEXUALLY TRANSMITTED DISEASE
- ❑ Other (Please Specify) _____

IF DESIRED, PLESE INDICATE RESTRICTIONS TO THIS RELEASE BY CHECKING APPROPRIATE BOX PROVIDED ABOVE

THIS MEDICAL FACILITY IS HEREBY RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE MEDICAL INFORMATION REQUESTED.

SIGNATURE OF PERSON GIVING CONSENT_____DATE_____

RELATIONSHIP IF NOT PATIENT

(AUTHORIZATION MUST BE SIGNED BY THE PATIENT OR BY LEGAL GUARDIAN IN THE CASE OF A MINOR OR WHEN PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT.)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE OF SIGNATURE, UNLESS REVOKED EARLIER IN WRITING

NOTE: COMPLETION OF EACH POINT OF THIS FORM ENSURES COMPLIANCE WITH THE POLICIES OF THIS MEDICAL FACILITY, THE STATE OF ILLINOIS AND/OR FEDERAL CONFIDENTIALITY LEGISLATION DESIGNED TO PROTECT THE RIGHTS OF THE PATIENT. INFORMATION SO RELEASED IS INTENDED SOLELY FOR USE AS SLATED ABOVE AND IS NOT TO BE RELEASED TO OTHER SOURCES WITHOUT AGAIN SEEKING WRITTEN INFORMED CONSENT OF THE PATIENT.