CLARENDON HILLS FAMILY MEDICINE

99 Park Avenue, Suite 102
Clarendon Hills, IL 60514
630.455.7000 Phone 630.455.7001 Fax

Release of Confidential Health Information

I, _____, hereby authorize_____,
Patient Name of Healthcare Facility, Physician, etc.

to release to: _____,
Name of Healthcare Facility, Physician, etc

_____,
Street address, City, State, Zip, Phone

the following information contained in the patient record of _____,
Patient's Name

born _____, residing at _____.
Patient's date of birth Patient's Address, City. State, Zip

_____ Entire Medical Record
_____ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment and HIV/AIDS records;
_____ Mental Health Treatment Records
_____ Alcoholism Treatment Records
_____ Drug Abuse Treatment Records
_____ HIV/AIDS Records
_____ Lab Reports
_____ X-Ray Reports
_____ Operative Notes
_____ Other

The above information shall be released for date of service _____ to _____.
Date Date

The purpose of this authorization is _____
_____.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by the law.
I understand that the practice may not condition treatment on whether I sign this authorization except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Heath Information will terminate on _____.

Signed:_____ Date:_____

Print Name:_____

If you are not the patient specify your relationship to the patient:_____