AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA Compliant Request for Information

PLEASE PRINT CLEARLY

PATIENT'S NAME_____
(FIRST) (MIDDLE NAME) (LAST)

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

PHONE ( )_____DATE OF BIRTH_____SOCIAL SECURITY#_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF MEDICAL INFORMATION

FROM/TO	**TO/FROM**
DR. Southwest Physicians Group	**DR.** _____
Address 4861 West 95th Street	**Address** _____
City/ State, Zip Oak Lawn, Illinois 60453	**City/ State, Zip** _____
Phone (708) 423-2880	**Phone** _____

The following information may be released:

_____ Laboratory	_____ Progress / Doctor's Notes	_____ Release a 2 year abstract of my records
_____ Radiology	_____ Medication Records	_____ All Records
_____ Pathology	_____ Immunization Records	_____ Other

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

I am requesting my PHI to be disclosed for the following purpose:

☐Change of Insurance ☐Continuing Care ☐Referral ☐Other_____

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above ***are to be released through this authorization*** unless specified below:

DO NOT RELEASE (*Check all that apply*): **☐HIV** **☐Behavioral Health** **☐Drug/Alcohol**

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient (If not the patient, please state relationship) **Date**

_____ _____

Signature of Parent/Guardian or Personal Representative (Attach proper documentation) **Date**