Authorization for Release of Confidential Health Information

Patient name: _____ Telephone: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ Medical Record # (office use) _____

I hereby authorize the protected health information regarding the above-name person to be exchanged by (check one)
□ **Mail** □ **Fax**

FROM: Person/Institution/Other: _____

Address, City/State/Zip: _____

Phone Number: _____ Fax Number:_____

To: Person/Institution/Other: _____

Address, City/State/Zip: _____

Phone Number: _____ Fax Number:_____

I authorize the release of information pertaining to the following time periods: From date: _____ To date (s) : _____

The following types of information to be disclosed are as follows:
□ Visit Notes (excluding any confidential items checked below)
□ Allergy Test results
□ Diagnostic reports (labs, x-rays, etc)
□ Other: _____

The following highly confidently CONFIDENTIAL items must be checked off to be included in the disclosure:
□ HIV/AIDS related health information/records (410 ILCS 305/9)
□ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
□ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
□ Genetic testing information/records (410 ILCS 513/30)

The purpose of this authorization is (are): _____

This authorization expires (date): _____ . If not specified, this release will expire 1 year after the date of the signature.

- 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 law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care 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 redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless it is 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 disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Advanced Allergy & Asthma Associates to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

Date: _____ Relationship to patient: _____

Staff Signature: _____ Date: _____
(to verify signer's identity) (must be dated)