North Suburban Family Medicine

150 N. River Road, Suite 310
Des Plaines, IL 60016
Phone 847-795-0900/ Fax 847-795-0955

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Step I: Patient Name_____ Date of Birth_____

Address_____
Street City State Zip Code

Phone (_____)_____ Email _____

Step II: I hereby authorize:

To release my health information to:

Step III: Information to be released: __entire chart ___lab reports ___radiology reports ___hospital records

Other_____

Step IV: Purpose of Disclosure: __Continuity of Care ____Transfer of Care ___other_____

Definition: Sexually Transmitted Disease (STD) includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

__ Yes __No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

__ Yes __ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations

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Signature and Date **(If you are not the patient, please specify your relationship to the patient)**