Authorization Form for Release of Confidential Health Information

DIANE L. OZOG, MDSC 130 S. Main Street – Suite 202, Lombard, Illinois 60148

I, ______________________________, hereby authorize ___________________________to use and/or
(Name of Patient or Personal Representative) *(Name of Physician, Person or Entity)*

disclose a copy of the specific health and medical information identified below for
_________________________________, ____________________,
(Patient's Name) *(Date of Birth)*
____,
(Street Address, City, State and Zip Code)

to ____
(Name of Recipient, Health Care Facility, Physician, Agency, etc.)
____
(Street Address, City, State and Zip Code)

for the following purposes (describe each purpose): ____
____
____.

By my initials in the spaces below, I specifically authorize the use and/or disclosure of the following health and medical information and/or medical records, if such information and/or records exist:

Initial all that apply:

__ The entire medical record, ***excluding*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/Acquired Immune Deficiency Syndrome (AIDS) records.

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And/or the following medical information as limited to or to include:

__ Information requested on School / Camp Form
__ Laboratory Reports
__ X-ray related Reports
__ Operative Notes
__ Billing Statements

__ Allow Qualified Individual as Personal Representative ________________________
Name of: Parent/Guardian/Friend,etc
__ Alcoholism Treatment Records
__ Drug Abuse Treatment Records
__ Mental Health Treatment Records

___ Other: ____

I understand that I have the right to inspect and copy the information I have authorized to be use or disclosed under 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 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 action has been taken already reliance on this authorization to use or disclose my health information. Written revocation must be sent to the physician's office.
Medical Record Copy Fees: Under Illinois law (Public Act 92-228), the amount a physician or other health care provider may charge for copying medical records is limited. For 2010 the maximum amounts a physician can charge for copying medical records is as follows:
89¢ each for pages 1-25, 59¢ each for pages 26-50, 30¢ each for pages 51 to end, plus actual postage. Note: $1.49 per page if electronic.

Unless revoked in writing at an earlier date, this authorization will expire on: ____________ (in 1 year).
(Date)

Signature: ____ Date: ________________

If you are not the patient, please specify your relationship to the patient: _______________________.