QUINTESSENTIAL care

850 S. Wabash Ave., Suite 210
Chicago, IL 60605

(312) 942-5100 *Office*
(312) 942-5109 *Fax*

Authorization for Use and Disclosure of Medical Information

_____ _____
Patient Name (PRINT) Date of Birth

REQUEST FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
This authorization allows the healthcare provider(s) named below to release confidential information and records.
Note: Records regarding treatment of minors, HIV, mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize (Physician/Healthcare Facility) _____ **to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods to:**

Name: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: _____ Fax: _____

Email:_____

The medical information will be used for the following purpose: _____

_____

This authorization is: ☐ Unlimited *(All Records, Except Mental Health, Substance Abuse, HIV)*

☐ Limited to the following information: _____

☐ Other: _____

I also consent to the specific release of the following records: *(Indicate by Initialing)*

_____ Alcohol/Drug/Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Diagnosis/Treatment

DURATION
This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS
Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of Patient or Legal Representative Relationship, if Other Than Patient

_____ _____
Patient Name (PRINT) Date