

4905 Old Orchard Rd., Suite 634

(312) 598-3520 Office (312) 598-3525 Fax

Authorization for Use and Disclosure of Medical Information

Patient Name (PRINT)		Date of Birth
		Date of Birth
This authorization allows the healthcare provider(s) nam. Note: Records regarding treatment of minors, HIV, mentathat require specific authorization.	ed below to release of	
AUTHORIZATION		
I hereby authorize (Physician/Healthcare Facility)		to release
information regarding my medical history, illness or inju	ıry, consultation, pre	scriptions, treatment, diagnosis or prognosis,
including x-rays, correspondence and/or medical record	ls 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 p	ulikuose.	
The medical information will be used for the following p		
This authorization is: ☐ Unlimited (All Records, Except I	 Mental Health, Subst	tance Abuse, HIV)
☐ Limited to the following information:		
☐ Other:		
I also consent to the specific release of the following red	cords: (Indicate by Ind	itialing)
Alcohol/Drug/Substance Abuse Psychi	iatric/Mental Health I	Information HIV Diagnosis/Treatment
DURATION This authorization shall be effective immediately and ren	nain in effect until	
Date		
RESTRICTIONS Permission for further use or disclosure of this medical inf me or unless such disclosure is specifically required or pe considered as effective and valid as the original. I have be	ermitted by law. A phot	tocopy or facsimile of this authorization shall be
Signature of Patient or Legal Representative		Relationship, if Other Than Patient
Patient Name (PRINT)		Date