AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name	
DOB:	
Address	
City, State, Zip	
Phone:	

MEDICAL INFORMATION REQUESTED FROM:

DOCTOR / FACILITY	
Address	
City, State, Zip	
Phone / Fax:	

MEDICAL INFORMATION RELEASED TO: □ Dr. Lindsey Babbin □ Dr. Angela M. Bell □ Dr. Tyson Stock

Chicagoland Complete Healthcare, 3000 N Halsted, Suite 401, Chicago, IL 60657, Telephone: 773-935-5985 Fax: 773-935-5478

PURPOSE: ☐ Continuation of Care ☐Other (specify): ____

DATES: **From ____/_____/_____** **To _____/_____/_____** **OR** ☐All Dates of Service

REQUESTED MEDICAL INFORMATION:

STEP 1 OF 2 **(OFFICE USE ONLY BELOW)**	STEP 2 OF 2 *Witness Signature required on page 2
□ Progress/Physician Notes □ Consultation report □ Complete Vaccination Record □ Laboratory report □ Mammogram report □ PAP Smear / Colposcopy □ C-Scope report □ X-ray / Radiology / Ultrasound / CT / MRI Reports □ EKG / EMG / EEG / Stress Test / Cardiac Test □ Pathology Report □ Emergency report □ Operative Report	If your previous medical records contain ANY of the following information, you must initial and date next to each applicable line in order to have those areas of your medical records released to Chicagoland Complete Healthcare. This applies to any testing, medications taken or prescribed and/or discussions contained in your records. Note: Mental Health includes anxiety, depression and other stress-related diagnosis. □ Genetic Testing Initial _________ Date ____________ □ Drug / Alcohol Initial _________ Date ____________ □ HIV Initial _________ Date ____________ □ Mental Health / Developmental Disability Initial _________ Date ____________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above.

I understand that I have the right to revoke this authorization at any time. I understand the revocation must be in writing and must be sent to the attention of Medical Records at Chicagoland Complete Healthcare, 3000 N. Halsted, Suite 401, Chicago, IL 60657. The revocation will not apply to the extent that CCHC has already taken action in reliance on the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand I have the right to inspect and/or receive a copy of the medical information to be used or disclosed and also receive a copy of this authorization form.

I understand I have the right to refuse to sign this authorization and CCHC does not condition treatment on the provision of the authorization for the requested use of disclosure, except disclosure necessary to determine payment of claim (excluding authorization for the use or disclosure of psychotherapy notes); or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g., pre-employment or life insurance physicals).

EFFECTIVE: This authorization request does not apply to any treatment dates beyond the date of signature. You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire, unless mental health records are requested. Otherwise, this authorization will expire ninety (90) calendar days after the date of this signature.

____ ______________________________________

Signature of Patient or Personal Representative **Date**

____ ______________________________________

If signed by other than patient: PRINT representative name Phone Number

____

If signed by other than patient: STATE relationship

*Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if patient over the age of 12 and under the age of 18.

____ ______________________________________

Witness Signature Date

____ ______________________________________

PRINT Witness Name Phone Number

____

State Relationship to patient