AUTHORIZATION
Michigan Avenue Internists, L.L.C.

200 S Michigan Avenue, Suite 805 | Chicago, IL 60604
312-922-3815 | 312-922-7449 (fax) | www.MichiganAvenueInternists.com

Patient Name: ______________________

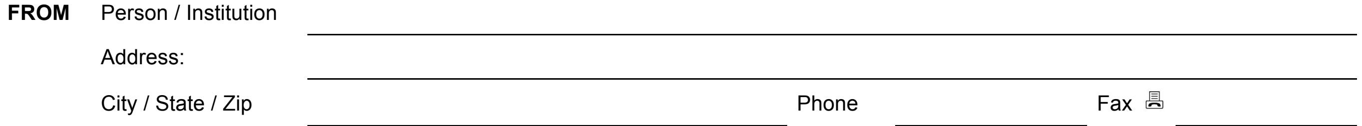
Address: ______________________

Phone Number ______________________

Date of Birth ______________________ SS Number (optional): ____________

Authorization for Release of Patient Health Information

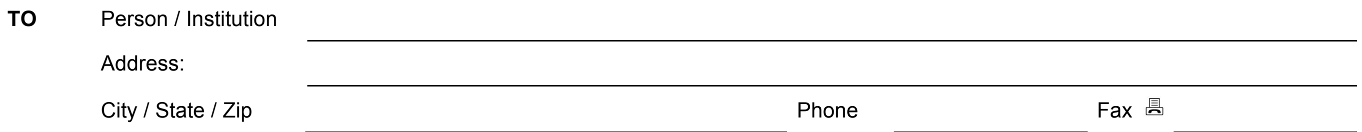
I hereby authorize that the protected health information regarding the above named person be forwarded



FROM Person / Institution ______________________

Address: ______________________

City / State / Zip ______________________ Phone ____________ Fax ____________



TO Person / Institution ______________________

Address: ______________________

City / State / Zip ______________________ Phone ____________ Fax ____________

Purpose or need for information: ______________________

Disclosure will include (Check one or more)

- ☐ Face Sheet
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Physician's Notes
- ☐ Radiology Report
- ☐ Pathology Report
- ☐ Emergency Report
- ☐ Nurse's Notes
- ☐ EKG/EMG/EEG Report
- ☐ Consultation Report
- ☐ Other: ______________________

Records for the period of (dates) ____________ to ____________

I must check one or more of the following types of health information that I do NOT want released to the above named recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named recipient may include any of the following...

☐ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
☐ Records of HTLV-III or HIV testing (AIDS test) results, diagnosis and/or treatment
☐ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatments plans and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have the right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I allow my health information to be used or disclosed to others.

______________________ ____________

Signature of Patient — Date

______________________ ____________

Signature of Parent / Legal Guardian / Personal Representative — Relationship to Patent

____

Witness

Redisclosure: Notice is hereby given to the patient signing this Authorization that Michigan Avenue Internists, L.L.C. cannot or that the Recipient receiving the requested health information will not disclose any of it to other parties. Notice is hereby given to the Recipient that the law prohibits the redisclosure of any information regarding drugs, alcohol, HIV or mental health treatment.

REGISTRATION

Michigan Avenue Internists, L.L.C.

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Date ______________________ (PLEASE PRINT)

PATIENT INFORMATION

Name ______________________ Soc. Sec # ______________
Last Name First Name Initial

Address ______________________ Home ____________ Cell ____________

City ______________________ State ____________ Zip ____________

Pharmacy ______________________ Pharmacy ____________ Pharmacy Fax ____________

Pharmacy City ______________________ State ____________ Zip ____________

Gender ☐M ☐F Age ____ Birthdate ________ ☐Single ☐Married ☐Widowed Email ____________

Patient Employed by ______________________ Occupation ____________

Business Address ______________________ Work ____________

Spouse or Parent Name ______________ Employer ____________ Work ____________

Whom may we thank for referring you? ______________________

In case of emergency who should be notified? ______________________ Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ______________________
Last Name First Name Initial

Relation to Patient ______________ Birthdate ____________ Soc. Sec # ____________

Address (if different from patient's) ______________________ Home ____________

City ______________________ State ____________ Zip ____________

Person Responsible Employed by ______________________ Occupation ____________

Business Address ______________________ Work ____________

Insurance Company ______________________

Policy # ______________ Group # ______________ Subscriber # ______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Relation to Patient ____________ Birthdate ____________

Address (if different from patient's) ______________________ Home ____________

City ______________________ State ____________ Zip ____________

Subscriber Employed by ______________________ Work ____________

Insurance Company ______________________ Soc. Sec # ____________

Policy # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ____________
Responsible Party Signature Relationship Date

PATIENT CONSENT FORM
Michigan Avenue Internists, L.L.C.

- If we do not have confirmation of your insurance coverage either by a current insurance card or letter of eligibility from your insurance company or employer, you, the patient, are responsible for any charges incurred at the time of your visit. This remains in effect until such time this information is received by this office.
- Many insurance companies do not cover preventive medicine or screening tests (i.e. physical examinations, cholesterol screening) even though your physician may find it necessary. If this is the case and you agree to proceed with this test, you are responsible for payment.
- If your insurance company does not cover certain services deemed necessary by your physician and you agree to proceed with these services, you are responsible for payment.
- It is your responsibility to know what your insurance company will cover.
- It is your responsibility as the patient to know if your physician is "in-network".
- Michigan Avenue Internists require that each patient presents his or her current insurance card before *every* visit.
- Please note that effective April 1st 2009 Michigan Avenue Internists may assess a $25.00 fee for medical advice or treatment given over the phone. If you have any concerns this policy, your physician would be happy to discuss this further.

I have read and understand the above statements and accept liability for all services rendered.

Patient Name (print): ______________________________

Patient Signature: ______________________________

Date of Notice: ______________________________

CONSENT FOR RELEASE
Michigan Avenue Internists, L.L.C.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, _________________________, hereby give my consent to Michigan Avenue Internists, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of patient.

I acknowledge that the physician's Notice of Privacy Practices has been made available to me upon request at the front desk. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that this practice is using an electronic health record information system (the "**EHR System**"), in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. The information collected through the EHR System may include information regarding my diagnosis and treatment for mental health, developmental disabilities, HIV, AIDS, drug and alcohol abuse, genetic testing and counseling. The EHR System is not equipped to segregate such data from my other health information. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, which may include: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database for any of the above activities.

I consent to the above disclosures of my health information regarding my treatment for mental health, developmental disabilities, and genetic counseling. With respect to any research activities, I understand that personal information that identifies me will be removed and my health information will be used in a way that does not identify me. I also understand that I may revoke my consent to disclose my health information relating to my treatment for mental health, developmental disabilities, HIV or AIDS, and genetic counseling by providing written notice to the Practice. My written revocation shall not apply to disclosures already made by the Practice and NMH based upon the above consent. If not revoked, the above consent will expire two years from the date below. I understand that I have the right to inspect and copy any information to be disclosed regarding mental health, developmental disability or genetic counseling services, and that such information may not be re-disclosed by any recipient without my further consent.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me at my next office appointment.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use of disclose my health information. Written revocation of consent must be sent to the physician's office.

____ _____________________

Signed Date

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