AUTHORIZATION

Michigan Avenue Internists, L.L.C.

200 S Michigan Avenue, Suite 1400 | 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.