Patient Name_____

Address_____

Phone Number_____

Date of Birth_____

Sobel Medical Associates, Ltd.
30 N. Michigan Ave Suite 1720
Chicago, IL 60602
Phone: 312-726-0005 Fax: 312-726-0011

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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

FROM ("Sender"):
Person/Institution _____
Address: _____
City_____ State_____ Zip_____

To ("Recipient"):
Person/Institution _____
Address: _____
City_____ State_____ Zip_____

Purpose or use of this information: _____

The information requested as checked below is for the dates of service: From _____ To_____

Please provide the following record information:

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ Emergency Report
- ☐ Hospitalization Reports
- ☐ History & Physical
- ☐ Progress/Physician Notes
- ☐ Nurse Notes
- ☐ Laboratory Report
- ☐ X-Ray/Radiology Reports
- ☐ EKG/EMG/EEG Reports
- ☐ Pathology Report
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Other _____ _____

IMPORTANT: If I **DO NOT** want one or more of the following types of health information released to the above named Recipient, I must **check one or more** of the following boxes. I understand that if **I do not check** any of the four (4) following boxes, the health information released to the Recipient may include any of the following:

- ☐ Alcoholism and/or Drug Abuse Treatment Records
- ☐ Mental Health Treatment Records
- ☐ HIV/Acquired Immune Deficiency (AIDS) Records
- ☐ Genetic Testing

I understand that I may revoke this Authorization at any time by giving written notice to Sender's Privacy Officer, except to the extent that Sender has already relied on this Authorization to release my health information. This Authorization shall remain valid unless revoked but will expire 12 months from the date of signing. I understand that I have the right to inspect and copy the information to be released pursuant to this Authorization, and that if I do not sign this Authorization, Sender will not release my health information, except as provided by law. I understand that Sender will not condition treatment on whether I sign this Authorization, except when the provision of health care is solely for the purpose of creating health information for disclosure to a third party. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient and may no longer be protected by law, and that Sender cannot guarantee that the Recipient will not disclose any or all of it to others.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Legal Guardian/Legal Representative
(Required if Patient is not legally authorized to sign Authorization)

Relationship to Patient and/or Basis of Authority

_____

Witness