NORTHWEST SUBURBAN MEDICAL ASSOCIATES, S.C.
Specializing in Infectious Diseases

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Authorization Form for Release of Confidential Health Information From Northwest Suburban Medical Associates, SC

I, _____, hereby authorize Northwest Suburban Medical Associates, SC
(Patient/Guardian Name)

To release to following information to: _____ located at
(Name of Healthcare Facility/Physician)

_____
(Address, City, State, Zip of Healthcare Facility/Physician)

Patient record of _____, Born _____, residing at
(Patient Name) (Date of Birth)

_____
(Patient Address, City, Zip)

- ☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
- ☐ Mental health treatment records
- ☐ Alcoholism treatment records
- ☐ Drug abuse treatment records
- ☐ Laboratory reports
- ☐ X-ray reports
- ☐ Operative notes
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) records
- ☐ Other (please list):

The above information for the following period of time shall be released: From _____ to _____.
(Date) (Date)

The purpose(s) of the authorization are: _____

~ I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

~ I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

~ 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 that this authorization is valid until it expires, unless revoked before that.

~ I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signed: _____ Date: _____