

MRN _____

Patient Name _____

Date of Birth _____

I Hereby authorize **Chicago Podiatric Surgeons**, of Chicago, IL, 312-337-9900, to disclose the above named individual's health information as described below:

Dates of Service Requested (if known): _____

Description of Information to be released: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Patient Information Form |
| <input type="checkbox"/> Radiology/Imaging Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Other: _____ |

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

_____	_____	_____	_____	_____
Name	Address	City	State	Zip

Telephone Number: _____

Description of the purpose of the use and/or disclosure:

- | | | |
|--|--|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Social Security/Disability |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other: Please Describe: _____ | |

I understand that this is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law in 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until: _____ (date or event).

I understand that I may revoke this authorization at any time by notifying Chicago Podiatric Surgeons. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date later than the date on this authorization. The revocation will not affect actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

Relationship to Patient

Legal Authority (attach supporting documentation)