OAK BROOK allergists

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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Former Name: _____

I HEREBY AUTHORIZE OAK BROOK ALLERGISTS TO RELEASE COPIES OF MY MEDICAL RECORD TO:

Name: _____
(if an individual, describe the relationship to the patient)

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INFORMATION REQUESTED:

- ☐ All Records
- ☐ Abstract Only (Most Recent History & Physical, Office Notes, Testing Results)
- ☐ Lab/Test Results
- ☐ Office Visit Notes

Approximate dates of service: _____

PURPOSE OF DISCLOSURE:

- ☐ Physician/Organization for continuation of care
- ☐ Personal Use
- ☐ Legal
- ☐ Other (Please specify): _____

I DO NOT AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION (SPECIFY):

_____

Please read the following statements carefully:

- I understand I have the right to review and obtain the information to be disclosed and receive a copy of this authorization form.
- I understand that medical information disclosed through this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state health information privacy laws.
- I understand that I may revoke this authorization at any time by giving written notice to Oak Brook Allergists except to the extent that Oak Brook Allergists has already acted in reliance on this contract.
- I understand this authorization will terminate ninety (90) days after my date of signature.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Printed Name of Patient's Representative **Relationship to Patient**

_____ _____
Witness **Date**