Lake Street Family Physicians
1010 Lake St., Suite 500
Oak Park, IL 60301
708-524-8600
FAX: 708-524-8147

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the physician and/or administrative and clinical staff at:

_____
Physician or Practice Name

_____
Address City State Zip Code

_____
Phone number Fax Number

To use and/or disclose a copy of the specific health and medical information identified below for:

_____
Patient Last Name First Name Date of Birth

Send records to:

_____
Name

_____
Address City State Zip Code

_____
Phone Number Fax Number

By initialing the space(s) below, I specifically authorize the use and/or disclosure of the following health information and/or records, if such information and/or records exist:

Please send the following medical records from (dates) _____ to _____.

___ENTIRE MEDICAL RECORD
___Progress Notes ___Laboratory Notes ___Diagnostic Imaging
___Consult Notes ___Pathology Reports ___Billing Statements
___HIV/AIDS related information/records ___Mental Health Information/records
___Genetic testing information/records ___Drug/alcohol information/records
___Other, please specify: _____

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This protected health information is being used or disclosed for the following purposes:

___Transfer to another facility **___Research study**
___ Insurance request **___Legal consultation**
___Other, please specify: _____

I understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy any information used/disclosed under this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice Manager except to the extent that action has been taken in reliance of this authorization. Unless revoked earlier, this authorization will expire 1 year from the date of signing.

The fee for copying/releasing medical records is: $35.00 and is payable upon receipt of this authorization.

Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative* **Date**

***Description of Personal Representative's Authority: _____**