Lake Street
FAMILY PHYSICIANS
1010 Lake St, Suite 301
Oak Park, IL 60301
Phone: 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 **___Vaccination record only (no charge)**
___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 physician/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: _____**