Patient ID: _____

Authorization for Release of Confidential Health Information

Patient name: _____ Telephone: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

I hereby authorize the protected health Information regarding the above-named person to be exchanged to the following person(s) listed below:

Person/Institution/Other: _____

Phone #: _____

I authorize PSGC to release information concerning my health information listed below: I authorize that my information may be release in the form of all methods checked below.

- Telephone
- With a person listed above
- Mail to: office or home
- Fax to: Home/Office, Fax number: (_) _____

The following types of information to be disclosed are as follows:

- Office Visit Notes
- Operative Reports
- History and Physical exam
- Labs, X-rays, films
- Picking up Records
- Take messages concerning health information
- Test Results
- Insurance/Billing statements
- Other: _____

The following Highly Confidential items must be checked off to be included in the disclosure:

- Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- HIV/AIDS related information/records (410 ILCS 305/9)
- Drug/alcohol diagnosis, treatment, referral Information (20 ILCS 301/30.5; 42 CFR pt. 2)
- The release of information involving a direct or indirect payment to Pain Specialist of Greater Chicago S.C from a third party: for the sale of protected health information or for marketing.

This authorization release will expire 1 year after the date of your signature.

- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above-described information, I understand it will not be disclosed except as provided by law.
- I understand that the practice may not condition on whether I sign this authorization, except when the provision of healthcare 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 redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until expires, unless revoked before that.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I have been provided a copy of the PSGC Notice of Privacy Practices. By my signature, I knowingly and voluntarily authorize Pain Specialist of Greater Chicago S.C to use of disclose my health information in the manner described above.

Please Contact our office immediately to make any changes to your HIPAA Form.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

Date: _____ Relationship to the patient: _____

Staff Initials: _____ Date: _____

Pain Specialist of Greater Chicago S.C

7055 High Grove Blvd Suite 100

Phone: 630-371-9980

Main Fax: 630-371-1555