WESTERN SPRINGS FAMILY PRACTICE CENTER

5600 S. Wolf Rd., Suite 140
Western Springs, IL 60558
708.246.7222 Phone 708.246.7286 Fax

Release of Confidential Health Information

I, _____, hereby authorize_____, to release to:
(Patient) (Name of Healthcare Facility, Physician, etc).

_____,_____
(Name of Healthcare Facility, Physician, etc.) (Street Address, City, State, Zip, Phone)

the following information contained in the patient record of _____, born _____
(Patient's Name) (DOB)

residing at _____.
(Patient's Address, City. State, Zip)

_____ Entire Medical Record
_____ Lab Reports Only
_____ X-Ray Reports Only
_____ Operative Notes Only
_____ Other _____

I must check one or more of the following types of health information that I *do not want released* to the above named recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

___Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse;
___Records of HTLV-III or HIV testing (AIDS test), result, diagnosis and/or treatment;
___Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

The above information shall be released for date(s) of service _____ to _____.
(Date) (Date)

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by the law.
I understand that the practice may not condition treatment 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 disclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Heath Information will terminate in *three months* unless specified as follows: _____.
REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that WSFPC cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIC and mental health treatment.

Signed:_____ Date:_____

Print Name:_____ Date of Birth:_____

If you are not the patient specify your relationship to the patient:_____