PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO TLC MEDICAL GROUP, SC

I authorize the following physician/medical practice to use or disclose the following information from the medical/health records of the person specified below.

Records to be transferred from:

Physician/Practice Name:_____ Phone:_____

Street Address:_____ City:_____ Zip Code_____

1. **Patient Information**:

Name of Patient: _____ DOB: _____

Street Address: _____ City: _____ Zip Code: _____

2. **Type of Patient health information to be disclosed:** (check all applicable boxes)
   - ☐ The **entire medical record** (which may include highly confidential records including Behavioral or Mental Health records, HIV/AIDS test results & records, Drug/Alcohol discussions and treatments, and Genetic Testing information/records)
   - ☐ Medical records dated from _____ to _____
   - ☐ Only Behavioral/Mental Health records
   - ☐ Only HIV/AIDS test results and records
   - ☐ Only Drug/Alcohol related records
   - ☐ Only Genetic Testing information/records
   - ☐ Other (please specify)_____

3. **The information specified above will be disclosed to: TLC Medical Group, S.C.**
   40W222 LaFox Rd (Suite J1)
   St. Charles, IL 60175

4. **This information will be disclosed for the purpose of:**
   - ☐ At the request of the individual/guardian
   - ☐ Continuation of care at the specified facility
   - ☐ Other: (please specify) _____

5. **Expiration Date: This authorization expires on**: _____

6. 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 law.
6. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
7. I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
8. I understand that this authorization is valid until the expiration date specified above, or if not specified, 1 year from the date of the signature.
9. 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.
10. 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. By my signature, I knowingly and voluntarily authorize the entities to use or disclose my health information in the manner described above.

Printed Name of Patient/Legal Guardian: _____

Signature: _____ Date: _____

Printed Name of Patient if 12 Years or Older:_____

Signature: _____ Date: _____