AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Ronnie Mandal DO SC
2740 W. Foster Ave # 101
Chicago, IL 60625
773-545-9500

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____
Address: _____
City/State/ZIP: _____
Phone: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize **Dr. Ronnie Mandal DO, SC** to release, disclose, and/or transmit copies of my medical records to the healthcare provider or medical practice identified below for purposes of continuity of care, evaluation, treatment, consultation, or other healthcare-related purposes.

RECIPIENT OF MEDICAL INFORMATION

Physician/Healthcare Provider: _____
Practice/Facility Name: _____
Address: _____
City/State/ZIP: _____
Telephone: _____
Fax: _____

INFORMATION AUTHORIZED FOR RELEASE

Please release the following medical information, as applicable:

☐ Complete medical record
☐ Consultation reports
☐ Laboratory results
☐ Imaging/radiology reports and images, if available
☐ Medication and prescription history
☐ Immunization records
☐ Mental/behavioral health information

☐ Substance use disorder treatment records, to the extent permitted by applicable law
☐ HIV/AIDS or other communicable disease-related information
☐ Genetic testing/information
☐ Other specially protected information: _____

PURPOSE OF DISCLOSURE

☐ Continuity of care / transfer of care due to closure of medical practice

PATIENT ACKNOWLEDGMENT AND SIGNATURE

I understand that:

1. I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization.
2. The revocation must be submitted in writing to the Internal Medicine Practice identified above.
3. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations, except where otherwise provided by applicable law.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned upon my signing this authorization, except where otherwise permitted by law.
5. I understand that I may request a copy of this signed authorization.
6. I authorize the release of the medical information identified above for the purposes specified in this authorization.

PATIENT / AUTHORIZED REPRESENTATIVE

Patient Signature: _____
Date: _____
Printed Name: _____

If signed by someone other than the patient:

Authorized Representative Name: _____
Relationship/Authority: _____
Signature: _____
Date: _____

This authorization should be completed and maintained in accordance with applicable federal and state privacy requirements and the practice's policies and procedures.