CHICAGO NEUROSCIENCE INSTITUTE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMTION

Patient Name	Birth Date	Social Security Number
Address	Telephone Number ( ) -	

I hereby authorize: **CHICAGO NEUROSCIENCE INSTITUTE**
1795 GRANDSTAND PLACE, ELGIN, IL 60123
PHONE: (847) 888-1811 FAX: (847) 888-1868

To release information from the medical records of _____
Patient Name

To:_____ _____ _____
Facility Name Phone Fax

_____ _____ _____
Address City Zip Code

For the following purpose:_____

For treatment of date(s):_____

Access Requested

- ☐ Copies of the record
- ☐ Inspection of the record
- ☐ Access to CDR

Select Portions of Medical Record Requested

- ☐ Abstract/Pertinent Info
- ☐ Emergency Room
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative/Procedure Reports
- ☐ Lab Studies
- ☐ Imaging/Radiology
- ☐ Cardiac Studies
- ☐ Face Sheet
- ☐ Nursing Notes
- ☐ Progress Notes
- ☐ Orders
- ☐ Entire Medical Record
- ☐ Other_____
  _____
  _____
  _____

This authorization expires 60 days from the date signed below and covers only treatment for dates specified above.

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information.
Initials

I, the undersigned, have read the above and authorize the staff of the named facility to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other that the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization. I understand federal and state laws permit a fee to be charged for copying of patient records.

_____ _____ _____
Date Signature of Patient/Parent/Conservator/Guardian Relationship to Patient/Authority to Act for Patient

_____ _____
ID Presented Verified By

THIS AUTHORIZATION WILL NOT BE VALID UNLESS ENTIRELY FILLED OUT

Notice to the Recipient: The recipient of the enclosed information is not authorized to use this patient's Medical Record information for any purpose other than for that stated above or to disclose any information to any other person or facility without specific written authorization from the patient to do so.

A copy of this completed, signed and dated form must be given to the Individual or other Authorized Representative upon request.