S&K MEDICAL CENTER

1S376 SUMMIT AVE, COURT C SUITE 4B, OAKBROOK TERRACE, IL 60181

DR. MUHAMMAD SHAHZAD, MD

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____
Address: _____
_____ Phone:
_____(Home) _____(Cell) _____(Work)

Date of Birth: _____/_____/_____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) to disclose/release the following information* (check all that apply):

☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other healthcare providers. ☐ Laboratory/pathology records ☐ Abstract/ Summary ☐ X-ray/radiology records ☐ Pharmacy/prescription records ☐ Billing records ☐ Other (describe specifically): _____

*Note: If these records contain any information from previous providers, you are hereby authorizing disclosure of this information.

Disclosure of information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease must be specifically authorized in the box below.

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for: _____ HIV/AIDS _____ Mental Health _____ Sexually Transmitted Diseases _____ Alcohol/Drug Abuse _____ Reproductive Care (minors only)

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____ _____ _____ Date
Signature of patient or patient's authorized representative Relationship to patient if not patient

These records are for services provided on the following date(s):
_____

Please send the records listed above to (use additional sheets if necessary): Name: _____ Name: _____ Address: _____ Address: _____ _____ _____ Phone: _____ Phone: _____ Fax: _____ Fax: _____

The information may be used/disclosed for each of the following purposes: □ At my request (only the patient can check this box) □ For my healthcare □ For payment/insurance □ For employment purposes □ Other: _____

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner) and may not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's Date personal representative)

_____ _____
Printed name of patient representative Representative's authority to sign for patient (i.e., parent, guardian, power of attorney for healthcare, executor)