Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize Ear, Nose & Throat
(Name of Patient or Authorized Agent)
Specialists of Illinois, Ltd. to release to:

_____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
(Street Address),

_____
(City, State and Zip Code)

the following information contained in the patient record of _____
(Patient's Name)
born _____, residing at _____:
(Birthdate) *(Street Address, City, State and Zip Code)*

- ☐ The entire medical record, ***excluding*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ Operative Notes
- ☐ Audio
- ☐ Other: _____

The above information for the following period of time shall be released:

From: _____ to _____.
(Date) *(Date)*

The purpose(s) of the authorization is (are) _____
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.

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. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure 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 Health Information will terminate on _____.

(Date)

Signed: _____ Date: _____

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

(rev 09/14)

8780 West Golf Road Suite 200 Niles, IL 60714 Fax (847) 824-7453
4905 Old Orchard Center Suite 630 Skokie, IL 60077 Fax (847) 674-5598
767 Park Avenue West Suite 220 Highland Park, IL 60035 Fax (847) 681-8620
1900 Hollister Drive Suite 220 Libertyville, IL 60048 Fax (847) 247-9123
2150 Pfingsten Road Suite 2260 Glenview, IL 60026 Fax (847) 998-0483
1475 East Belvidere Road Suite 212 Grayslake, IL 60030 Fax (847) 247-9123
2500 West Higgins Road, Suite 220 Hoffman Estates, IL 60169 Fax (847) 824-7453
1460 North Halsted Suite 506 Chicago, IL 60642 Fax (847) 824-0152
680 North Lake Shore Drive, Suite 1207, Chicago, IL 60611 Fax (312) 999-9401