Dr. Amishi Singal Murthy & Dr. Vivian Chou

COS Building • 2500 Ridge Ave • Suite 211A • Evanston, IL 60201
3000 Halsted Street • Suite 724 • Chicago, IL 60657
Phone: (847) 328-7909 • Fax: (847) 328-7919
www.ilallergyasthma.com

Authorization for Release of Confidential Health Information

Patient name:____ Telephone:____
Address:____ Date of birth:____
City/State/Zip:____ Medical record # (office only):_________________________

We take patient confidentiality very seriously. In addition to yourself or your child, please specify another person(s) with whom we may discuss your test results/health information, if so desired.

_____ I want my test results/healthcare information reported **only** to me

OR

_____ Dr. Chou and Dr. Murthy have my permission to speak with the following individuals only:

Name/Relationship/Telephone:
1)____
2)____
3)____

I hereby authorize the protected health information of the patient named above to be granted:

From:
Person/Institution: ___________________________
Address: ___________________________________
City: _______________________________________
State/Zip Code: ______________________
Phone: _________________________________

To:
Person/Institution: ___________________________
Address: ___________________________________
City: _______________________________________
State/Zip Code: _________________________
Phone: _____________________________________

I authorize the release of information pertaining to the following time periods:

From date(s):____ To date(s):____

The following types of information to be disclosed are as follows:

- □ History and physical examination
- □ Consultation reports
- □ Progress notes
- □ Operative reports
- □ Abstract (documents summarizing history)
- □ Diagnostic reports (labs, x-rays, etc)
- □ X-ray films
- □ Other:____________________________________

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- □ HIV/AIDS related health information/records (410 ILCS 305/9)
- □ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- □ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- □ Genetic testing information/records (410 ILCS 513/30)

□ The release of information involves a direct or indirect payment to Illinois Allergy and Asthma Specialists from a third party:

□ for the sale of protected health information.
□ for marketing.

The purpose(s) of this authorization is (are):

____

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This authorization expires (date):___________________. If not specified, this release will expire 1 year after the date of signature: PLEASE WRITE TODAY'S DATE: ______________.

- 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 disclosure my health information. Written revocation must be sent to the physician's office.
- 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 **Illinois Allergy and Asthma Specialists** to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent:____

Signature of patient or legal guardian, or authorized agent:____

Relationship to patient:___________________________

Date:____