Suburban Associates In Ophthalmology
1100 W. Central Road Suite 205
Arlington Heights, IL 60005
Phone: 847-253-4040 Fax: 224-232-5799

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Release Information **TO:**

Organization Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

Release information **FROM:** Suburban Associates In Ophthalmology

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By signing this authorization, I authorize my Health Care Provider to disclose my protected health in formation

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

_____

Covering periods of health care FROM (date) ____/_____/_____ TO (date) ____/_____/_____

1. Information authorized for disclosure, if included in my records:
   ____ Complete Record ___ Pathology Reports ____ Visit/ Discharge Summary
   ____ Laboratory Test ___ Doctors' Letters ____ Diagnostic Testing

2. If applicable, I also give permission for the following "Sensitive Protective Health Information" to be disclosed:
   ___HIV/AIDS related health information
   ___ Behavioral or mental health information
   ___ Diagnosis or treatment of drug or alcohol abuse

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3. The information for which I'm authorizing disclosure will be used for the following purpose:
   ____ My personal use
   ____ Sharing with other health care providers
   ____Other _____

4. **I understand** that I have the right to revoke authorization at any time: I understand that if I revoke this authorization I must do so in writing and present written revocation to the providers(s) of care. I understand that the revocation will not apply to the information that has already been release in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim

5. This authorization will expire (date) ____/_____/____ if not otherwise specified, this release will expire in 90 days.

6. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosure, as allowed by HIPAA and other federal privacy rules, if I have questions about disclosures of my health information, I can contact my provider of care.

7. The Facility, its employees, offers and physicians are hereby released from any legal responsibilities or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signature of Patient – (or Legal representative, Parent or Guardian)

_____

Relationship if not patient

_____

Date