Associated Allergists & Asthma Specialists, Ltd

Authorization for Release of Health Information

Instructions: Please complete this authorization to obtain copies of your medical records. You will be billed for medical records according to the Code of Civil Procedure 735 ILCS 5/8-2001.

Patient Name: _____ Phone #_____ Date of Birth: _____
Address: _____ City: _____ State _____ Zip Code _____

Medical Information Released To:
Name/Organization: _____ Phone # _____
Address: _____ City: _____ State _____ Zip Code _____

Method of Delivery: ___ US Mail ___ Pick up by Patient or Guardian (Name) _____ Photo ID Required
Information Requested: ___ Entire Medical Record ___ Other (Specify): _____

Sensitive Medical Information To Be Released: Required by the Patient (age 12-17 years old) In Order To Receive sensitive medical information, the following must be initialed and dated by the patient.

__ Mental Health/Developmental Disabilities	Initials_____ Date _____
__ Drug/Alcohol Use	Initials_____ Date _____
__ AIDS/HIV	Initials_____ Date _____
__ Genetic Testing	Initials_____ Date _____
__ Other	Initials_____ Date _____

This information I am authorizing to be released will be used for the following purpose:
__ My Personal Use __Physician/Organization __ Other (specify) _____

- I understand that this authorization is voluntary and I may refuse to sign it. If I refuse to sign this authorization, Associated Allergists & Asthma Specialists will not release my records.
- I understand that I may revoke this authorization in writing, at any time. I understand if I revoke this authorization, it will be effective only when Associated Allergists & Asthma Specialists receives it. I understand that my later decision to revoke this authorization will not affect any action, use, or disclosure in reliance on this authorization, which cannot be reversed.
- I understand that medical information disclosed through this authorization may no longer be protected by federal health information privacy laws. I also understand that sensitive medical information disclosed through this authorization may require my further authorization to be disclosed.
- I understand this authorization will terminate after ninety (90) days after my date of signature and will not be able to be disclosed beyond this date.

_____
Print Name of Patient/Legal Guardian

_____ _____ _____
Signature of Patient/Legal Guardian **Date** **Time**
(Patient must sign if requesting sensitive medical information, Twelve (12) years and older)

_____
Print Name of Witness

_____ _____ _____
Signature of Witness **Date** **Time**
(Attests to identity of Patient/Legal Guardian)