Internal Medicine & Family Practice, SC
1719 Glenwood Avenue Joliet, IL 60435
Phone: (815) 741-3532 Fax: (815) 741-3736

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE)

I give my authorization to use or disclose my (Patient or POA) protected health information as described below. I give this authorization voluntarily.

Patient Name: _____ DOB: _____

Representative Name (POA/Parent): _____

Patient/Rep Street Address: _____

Patient/POA City: _____ State: _____ Zip: _____

Patient/POA Telephone Number: _____

THE USE AND/OR DISCLOSURE AUTHORIZATION

All requested records will be released unless you write an exception below.

_____

Name the people and/or organizations (other MD's, attorneys....) that you are to disclose **(verbal)** the protected health information. Enter N/A if no information to be released.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Name the people and/or (other MD's, attorneys....) that you are authorizing to receive **(hard copy)** and use your protected health information. Enter N/A if no information to be released.

_____ _____ _____
_____ _____ _____
_____ _____ _____

ENDING THIS AUTHORIZATION

Select one of the following choices:

- This authorization will end on the following date: _____
- This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

_____
_____

CHANGING YOU MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at our office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization; the insurance company has a right to contest my claims under the insurance policy.

SIGNING THIS AUTHORIZATION IS NOT A CONDTION OF TREATMENT

I understand that most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstance, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

POSSIBILITY OF RE-DISCLOSURE

I understand that information disclosed under this authorization may me re-disclosed by the recipient. Federal privacy rules my not protect the privacy of my health information once the recipient re-discloses my health information.

INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protect health information described in this form with the people and/or organizations named in this form for ***a period of 5 years***.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print name

_____
Signature

Relationship to Individual Patient: _____

ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPURTUNITY TO REVIEW IT.

Name _____ Birthdate _____

Signature _____ Date _____

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