AUTHORIZATION FORM
FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I HEARBY AUTHORIZE: ____
Physician's Name / Medical Facility Name

____
Address

____
City State Zip Code

Phone: (____)__________________ Fax: (____)________________

TO RELEASE TO:
FARAH N. KHAN, M.D. F.A.C.P.
MILLENNIUM PARK MEDICAL ASSOCIATES, S.C.
30 SOUTH MICHIGAN AVENUE, SUITE #500
CHICAGO, ILLINOIS 60603
Phone: (312) 977.1185 Fax: (312) 977.1188

The following information contained in the patient record of:

Patient Name:____Date of Birth:____/____/______
First MI Last

Address: ____
Street City State Zip Code

_______ The entire medical record of ____, excluding Mental Health Treatment, Alcoholism Treatment, Drug Abuse Treatment, and HIV / AIDS records, unless indicated below.

To be disclosed, the following items must be specifically checked:

_______ **Mental Health Treatment Records**
_______ **Alcoholism Treatment Records**
_______ **Drug Abuse Treatment Records**
_______ **HIV / AIDS Treatment Records**

OR the following specific records only:

_______ **Laboratory Reports**
_______ **X-Ray Reports**
_______ **Operative Reports**
_______ **Other:**____

We request records from the following date or dates: From:____/____/_____ To ____/____/____

The Purpose of authorization is: *CONTINUITY OF CARE / NEW PCP / OTHER:*____________________

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 the 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___/___/_____.

Signed:
____Date:______/______/______

If you are not the patient, please specify relationship to patient: ______________________________