Northwest Pulmonary and Sleep Medicine

1340 Ryan Parkway. Algonquin, IL. 60102
Phone# 815-477-7350 and Fax # 815-477-7351

CONSENT TO REQUEST MEDICAL INFORMATION

PATIENT:_____ **D.O.B:**_____

ADDRESS:_____

The Undersigned Authorizes _____ **to release records to Northwest Pulmonary and Sleep Medicine.**

Please check (x) next to the following medical documentation related to the above named patient that may be released:
Information from the medical record of the above named patient:

_____ All Medical Record Information
_____ All Account Information
_____ Office Notes
_____ Consultation Report / Report of Patient's Condition
_____ Lab / X-ray or Testing Reports
_____ Psychological Testing
_____ Other: _____

IF APPLICABLE, please place your initials to denote specific permission is given to release medical information related to the following:

_____ Drug and/or Alcohol Abuse or Dependency
_____ Sexually Transmitted Diseases
_____ Acquired Immune Deficiency Syndrome (AIDS) Records
_____ Human Immunodeficiency Virus (HIV) Records
_____ Psychiatric Records

Please note any restrictions related to this release:

_____

The above information shall be released for the following period of time:
From: _____ to _____
(date) (date)

PURPOSE OF RELEASE _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. This release is valid until my care at this office is terminated or until I notify the office that I no longer want information sent to the above providers / agencies, or until _____ (date). A copy of this signature on this form is as valid as the original.

SIGNED: _____ DATE: _____
(Signature of patient or patient's legal guardian)

_____ _____
Print Patient's name Legal Guardian's Relationship to patient