Drs Girgis & Associates, S.C.

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Phone 630-323-5214
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Authorization for Release of Confidential Health Information

Patient name:_____ Telephone:_____
Address:_____ Date of birth:_____
City/State/Zip:_____ Medical record # (office only):_____

I hereby authorize the protected health information regarding the above-named person to be exchanged to:

Person/Institution/Other:_____
Address:_____
City/State/Zip:_____
Phone number:_____

I authorize the release of information pertaining to the following time periods:

From date(s):_____ To date(s):_____

The following types of information to be disclosed are as follows:

- □ History and physical examination
- □ Consultation reports
- □ Progress notes
- □ Operative reports
- □ Abstract (documents summarizing history)
- □ Diagnostic reports (labs, x-rays, etc)
- □ X-ray films
- □ Other:_____

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- □ HIV/AIDS related health information/records (410 ILCS 305/9)
- □ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- □ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- □ Genetic testing information/records (410 ILCS 513/30)
- □ The release of information involves a direct or indirect payment to ***Drs Girgis & Associates, S.C.*** from a third party:
  - □ for the sale of protected health information.
  - □ for marketing.

The purpose(s) of this authorization is (are):_____

This authorization expires (date):_____. If not specified, this release will expire 1 year after the date of signature:_____.

- 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 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 disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize ***Drs Girgis & Associates, S.C.*** to use or disclose my health information in the manner described above.

Patient Copying Charge Notification Sheet

Number of pages to be copied: _____ pages

Calculating the amount allowed under Illinois law:

Handling Fee			$31.56
Per Page Charges			
	Pages 1-25	$1.18 per page	$
	Pages 26-50	$0.79 per page	$
	Page 51 and over	$0.39 per page	$
Mailing Charges (actual postage fee)			$
For electronic records provided in an electronic format, reduce charge by 50% of per page fee.*			
Maximum Charge Under Illinois Law			$

*****Under Illinois law, for electronic records retrieved from a scanning, digital imaging, electronic information or other digital format provided in an electronic document, the Practice may charge 50% of the per page fee. No fee may be charged for the storage media, such as a CD Rom.

Printed name of patient, legal guardian, or authorized agent:_____

Signature of patient or legal guardian, or authorized agent:_____

Date:_____ **Relationship to patient:**_____

Staff signature:_____ **Date:**_____