

ELGIN FAMILY PHYSICIANS

87 N Airlite Street
Suite 130
Elgin, IL 60123

1435 Randall Road
Suite 301
Elgin, IL 60123

Phone 847-888-3661

Fax: 847-888-9964

CONSENT TO RELEASE INFORMATION

Patient Name: _____
Date of Birth: _____

Account #: _____

Information to be released From:

Name/Agency: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Information to be released to:

Name/Agency: **Elgin Family Physicians**
Address: **87 N Airlite Street Suite 130**
City/State/Zip: **Elgin, IL 60123**
Phone: **847-888-3661** Fax: **847-888-9964**

CHECK INFORMATION TO BE RELEASED:

- Progress Note Immunization Records Lab Reports Radiology Reports
- Consult/Referrals Hospital Records E/R Records
- Other (specify reports and dates of service) _____

Please check any items that you **DO NOT** want to be released. If left unchecked information will be released.

- STI's Mental Health Substance abuse (drugs/alcohol) HIV/Aids Genetic Testing Infectious Disease

This information is required for:

- Transfer of care Personal Copy Consultation/Referral
- Dissatisfaction with Clinic, please specify: _____

How would you like to receive your records?: Paper Records CD Flash Drive

I give my permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes that I have checked. I understand that this release is valid for 60 days and I may refuse to sign this authorization or revoke this authorization at any time. If I revoke or refuse to sign, it will not affect my ability to obtain treatment or my eligibility for benefits. The revocation will take effect on the day a signed copy is received by Elgin Family Physicians. I have the right to access my treatment records. Copies of my records may be obtained with reasonable notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal regulations or business associate of that organization that the information may be redisclosed and no longer protected.

Patient Signature: _____

Date: _____

Signature of Representative _____

Date: _____

Authority to represent individual: Parent Guardian Power of Attorney Authorized Representative

Name of Staff Member Initiating Release: _____ Date: _____

For Same Day Release: I have verified the identity of the patient and obtained a photo ID of the person to whom the authorized release is made:

Staff Signature: _____

Date: _____