



Authorization for Release of Medical Records from Ear, Nose & Throat Specialists of Illinois

I, _____ hereby authorize Ear, Nose & Throat Specialists of Illinois, Ltd.,
(Name of Patient or Authorized Agent)

to release the health records to:

Name of Health Care Facility/Agency: _____

Name of Physician: _____

Street Address: _____

City, State, Zip: _____

Release the following information contained in the patient record of:

Patient Name: _____ DOB: _____

Patient Address: _____

Information to be disclosed:

- Complete Health Record(s)
- Pathology Report(s)
- Operative Report(s)
- ER/Discharge Report(s)
- Laboratory Report(s)
- Radiology Report(s)
- Audiogram(s)
- Other (please specify): _____

Covering the period(s) of health care from: _____ to: _____

Please transfer requested information by this date: _____

Purpose of the authorization for the release of medical records: _____

Select the location of your provider:

<input type="checkbox"/> 2604 Dempster St. Suite 501 Park Ridge, IL 60068 F: (877) 409-1431	<input type="checkbox"/> 1900 Hollister Dr. Suite 220 Libertyville, IL 60048 F: (855) 576-4823	<input type="checkbox"/> 4905 Old Orchard Shopping Center Suite 630, Skokie, IL 60077 F: (888) 440-7957	<input type="checkbox"/> 2150 Pfungsten Rd. Suite 2260 Glenview, IL 60026 F: (877) 673-5330	<input type="checkbox"/> 2500 W Higgins Rd. Suite 1150 Hoffman Estates, IL 60169 F: (877) 673-5330
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If you were seen at the following locations, please send request to the corresponding offices:

Grayslake send to Libertyville | Highland Park send to Skokie | Yacktman Clinic send to Park Ridge

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 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

_____.
(Date)

Signature: _____ Date: _____
(Patient or Guardian)

If you are not the patient, please state relationship to patient: _____