Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

Pediatric
Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

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

I, _____, hereby authorize
(Name of Patient or Authorized Agent)

Name of Health Care Facility, Physician, Agency: _____

Street Address: _____

City, State, Zip: _____

to disclose the following information to Ear, Nose & Throat Specialists of Illinois, Ltd., from the health records 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: _____

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

_____

_____

This information will be disclosed to Ear, Nose & Throat Specialists of Illinois. Please mail or fax to (check location):

☐ 2604 Dempster St. Suite 501 Park Ridge, IL 60068 F: (877) 409-1431	☐ 1900 Hollister Dr. Suite 220 Libertyville, IL 60048 F: (855) 576-4823	☐ 4905 Old Orchard Shopping Center Suite 630, Skokie, IL 60077 F: (888) 440-7957	☐ 2150 Pfingsten Rd. Suite 2260 Glenview, IL 60026 F: (877) 673-5330	☐ 2500 W Higgins Rd. Suite 1150 Hoffman Estates, IL 60169 F: (877) 673-5330

Please transfer requested information by this date: _____

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: _____