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: ______________________________

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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: ____