



## 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:

**Ear, Nose & Throat Specialists of Illinois**  
**2604 Dempster St., Suite 501**  
**Park Ridge, IL 60068**  
**Phone: (847) 674-5585**  
**Fax: (877) 409-1431**

Please transfer requested information by this date: \_\_\_\_\_

**P: (847) 674-5585 | ENTIllinois.com**

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: \_\_\_\_\_