

**Lincoln Park Family Physician
1317 West Diversey Parkway
Chicago, IL 60614
Tel: (773) 665-9355
Fax: (773) 665-0403**

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED
HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Lincoln Park Family Physicians to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Lincoln Park Family Physicians to use and/or disclose to

_____, the following health information:
(person or entity to receive information)

(specifically describe the information to be released, such as date(s) of service and the level of detail to be released)

This authorization will expire on _____.
(expiration date)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Lincoln Park Family Physicians has acted in reliance upon this authorization. My written revocation must be submitted to Lincoln Park Family Physicians at 1317 W. Diversey Parkway, Chicago, IL 60614.

Signed by:

(Signature of patient/legal guardian)

(Relationship to patient)

(Patient's name)

(Date)

(Print name of patient/legal guardian)