

Lincoln Park Family Physicians Medical Records Release Form

Patient Name _____

Patient Date of Birth _____

Address _____

City / State / ZIP _____

Telephone # _____

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From / To (Circle One):

From / To (Circle One):

| | |
|---|-----------------------------|
| Person / Institution Lincoln Park Family Physicians | Person / Institution |
| Address 1317 W Diversey Pkwy | Address |
| City/ State / ZIP Chicago IL 60614 | City/State / ZIP |
| Phone/Fax 773-665-9355 / 773-665-0403 | Phone/Fax |

I authorize the release of information covering the period(s) of healthcare

From Date(s) _____ To Date(s) _____

The type of information to be used or disclosed is as follows:

- | | |
|--|---|
| <input type="checkbox"/> History and physical examination | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Abstract (documents summarizing health history) | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Diagnostic reports (labs, x-rays, etc.) | |

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

- HIV/AIDS related health information and/or records (the patient 12 or over must authorize this release)
- Behavioral or mental health information and/or records (release must be witnessed and the patient 12 or over must authorize this release)
- Information about sexually transmitted disease (the patient 12 or over must authorize this release)
- Pregnancy (the patient 12 or over must authorize this release)
- Birth control (the patient 12 or over must authorize this release)
- Drug/alcohol diagnosis, treatment, and/or referral information (the patient 12 or over must authorize this release)
- Genetic testing information and/or records
- Information about sexual assault/abuse
- Information about child abuse and neglect
- Domestic abuse of an adult with a disability

This information for which I'm authorizing disclosure will be used for the following purpose:

- My personal use (there is a fee for personal use copies)
- Sharing with other health care providers (no charge if sent directly to the provider – address must be provided as recipient above)
- Other (please specify) _____

I understand that once LPFP discloses my health information to the recipient, LPFP cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Lincoln Park Family Physicians to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____ Date: _____

(For information regarding Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Diseases, Pregnancy and Birth Control the patient 12 or over must sign to release these records)

If signed by Legal Guardian, relationship to patient: _____ Date: _____