Lifespan Medical Associates
250 West Kensington Road
Mount Prospect, IL 60056
Phone: 847-222-9595 Fax: 847-222-9565

Authorization for Release of Patient Health Information

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

To: Donald Novey, MD, Lifespan Medical Associates, 250 West Kensington Road, Mount Prospect, IL 60056

Purpose or need for information: _____

Disclosure will include (check all that apply)

All of the items below (or select them individually)

Face Sheet	History & Physical	Laboratory reports
Operative Reports	Discharge Summary	Progress/Physician Notes
X-ray/Radiology Reports	Pathology Reports	Emergency Reports
Nurses Notes	EKG/EMG/EEG Reports	Consultation Report

All available dates and content without restrictions (or select information individually below)

Records for the period (dates) from: _____ to: _____

I understand that the information to be released may include (initial all that apply)

_____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.

_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed by others.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Date

_____
Witness

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.