Patient Name_____

Address_____

Phone Number_____

Date of Birth_____

Medical Record Number_____

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 Ashwani K. Garg, M.D.

Address PO BOX 95825, HOFFMAN ESTATES, IL 60195-0825

Tel: (847) 994-5001

TO: (Recipient) Person/Institution_____

Address_____

City_____ State_____ Zip_____

Purpose or need for information:_____

Disclosure will include: (*check all that apply*)

☐Face Sheet ☐History & Physical ☐Laboratory Report ☐Operative Report ☐Other_____

☐Discharge Summary ☐Progress/Physician Notes ☐X-ray/Radiology Report ☐Pathology Report

☐Emergency Report ☐Nurses Notes ☐EKG/EMG/EEG Report ☐Consultation Report

Records for the period (dates) from _____ to _____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

_____**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 to others.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian/Personal Representative (Required if Patient is not legally authorized to sign Authorization) Relationship to Patient

_____

Witness