GCSP
greater chicago specialty physicians

AUTHORIZATION TO USE AND RELEASE HEALTH INFORMATION

Patient Information:

Name (First, Middle, Last):

_____

Phone Number: _____ Date of Birth: _____

Address:

Release Information FROM (check all that apply):	**Release Information TO:**
☐ Greater Chicago Specialty Physicians' facilities OR	❑ Greater Chicago Specialty Physicians' facilities OR
☐ Specify Other Physician/Facility: _____	❑ Name of Recipient: _____
Address: _____	Address: _____
City: State: Zip: _____	City: State: Zip: _____
Phone: _____	Phone: _____
	Delivery Preference: ❑ Pickup ❑ Patient Portal ❑ Mail ❑ Fax Number _____

The purpose of this release is:

❑ **Medical** ❑ **Change of Insurance:** ❑ **Legal:** ❑ **Transfer of care:** ❑ **Moving** ❑ **Other (specify):** _____

Release the following health information within the following dates:

FROM: _____ **TO:** _____ **OR** ❑ One year

❑ Progress Notes ❑ Radiology Reports ❑ Medication History ❑ ER Reports ❑ Specialist Consultation ❑ Lab Report(s)

❑ Entire Medical Record (includes HIV/AIDS test results/Alcohol/Drug Abuse) ❑ Other Records as specified: _____

_____

I understand:

- this authorization will remain in effect for one year from the date of authorization written below. You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices.
- there will be a charge for processing this request in accordance with Illinois law.
- that once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- the matters discussed on this form and release Greater Chicago Specialty Physicians, its employees, officers and directors and business associates from any legal responsibility or liability for the disclosure of the above information.

_____ _____ _____

Signature of Patient or Personal Representative | Printed Name of Patient or Personal Representative | Date

CLEAR FORM PRINT FORM