ELGIN FAMILY PHYSICIANS

901 Center Street
Suite 3000
Elgin, IL 60120

1435 Randall Road
Suite 301
Elgin, IL 60123

Phone 847-888-3661 Fax: 847-888-9964

CONSENT TO RELEASE INFORMATION

Patient Name: _____ Account #: _____

Date of Birth: _____

Information to be released From:

Name/Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be released to:

Name/Agency: Elgin Family Physicians

Address: 901 Center Street Suite 3000

City/State/Zip: Elgin, IL 60120

Phone: 847-888-3661 Fax: 847-888-9964

CHECK INFORMATION TO BE RELEASED:

☐ Progress Note ☐ Immunization Records ☐ Lab Reports ☐ Radiology Reports

☐ Consult/Referrals ☐ Hospital Records ☐ E/R Records

☐ Other (specify reports and dates of service) _____

Please check any items that you DO NOT want to be released. If left unchecked information will be released.

☐ STI's ☐ Mental Health ☐ Substance abuse (drugs/alcohol) ☐ HIV/Aids ☐ Genetic Testing ☐ Infectious Disease

This information is required for:

☐ Transfer of care ☐ Personal Copy ☐ Consultation/Referral

☐ Dissatisfaction with Clinic, please specify: _____

How would you like to receive your records?: ☐ Paper Records ☐ CD ☐ Flash Drive

I give my permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes that I have checked. I understand that this release is valid for 60 days and I may refuse to sign this authorization or revoke this authorization at any time. If I revoke or refuse to sign, it will not affect my ability to obtain treatment or my eligibility for benefits. The revocation will take effect on the day a signed copy is received by Elgin Family Physicians. I have the right to access my treatment records. Copies of my records may be obtained with reasonable notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal regulations or business associate of that organization that the information may be redisclosed and no longer protected.

Patient Signature: _____ Date: _____

Signature of Representative _____ Date: _____

Authority to represent individual: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

Name of Staff Member Initiating Release: _____ Date: _____

For Same Day Release: I have verified the identity of the patient and obtained a photo ID of the person to whom the authorized release is made:

Staff Signature: _____ Date: _____