

SSD Medical Group**Shazia Daudi, MD****Authorization for Release of Patient****Health Information**

12151 Regency Parkway, Suite 12165

Huntley, IL 60142

Phone: 847.230.9808 Fax: 847.984.1915

Patient name: _____

Date of Birth: _____

Address: _____

Telephone: _____

I hereby authorize the protected health information regarding the above-named person to be exchanged TO SSD Medical Group FROM:

Person/Organization Name: _____

Address: _____ Telephone: _____

I authorize the release of information pertaining to the following time periods:

From Date(s): SEE BELOWTo Date(s): SEE BELOW

The following types of information to be disclosed are as follows:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Mammogram & Bone Density – MOST RECENT | <input checked="" type="checkbox"/> Abstract (summary) and IMMUNIZATIONS |
| <input checked="" type="checkbox"/> Progress Notes – 1 YEAR OR MOST RECENT | <input checked="" type="checkbox"/> Lab Reports – 1 YEAR OR MOST RECENT |
| <input checked="" type="checkbox"/> Radiology Reports - 1 YEAR OR MOST RECENT | <input checked="" type="checkbox"/> Colonoscopy – MOST RECENT |
| <input type="checkbox"/> Other: _____ | |

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

The purpose(s) of this authorization is (are): FURTHER CARE

This authorization expires (date): _____. If not specified, this release will expire 1 year after the date of signature.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.
- I have read and understood 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 knowingly and voluntarily authorize SSD Medical Group to use or disclose my health information in the manner described above.

Signature of Patient or Legally Authorized Representative (List Relation)_____
Date_____
Signature of Witness_____
Date