Chicago Chest Center
INTERVENTIONAL PULMONOLOGY & THORACIC DISEASE

Suburban Lung Associates

Chicago Sleep Group

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Release From	**Release To**
(Practice/Doctor Name)	(Self/Practice/Doctor Name)
(Address)	(Address)
(City/State)	(City/State)
Phone#__________ Fax#__________	Phone#__________ Fax#__________

_____ Entire Medical Record(s)-Including any records in the file from other physicians OR only the following:

_____ laboratory results _____ progress note(s) _____ operative report(s)

_____ history and physical(s) _____ discharge summary _____ diagnostic test result(s)

_____ x-ray report(s) _____ consultation report(s)

_____ other (Specify)____

____

Date of Service: From: __________ To: __________

Reason for Request: ____

I fully understand that my medical record information, in connection with the treatment date(s) stated above, may contain AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus), mental health, developmental disabilities, and/or substance abuse test results or information. The medical record information disclosed is protected under State and Federal law and this privileged and confidential information may be disclosed only on my authorization, except as expressly required as law.

I understand that I have the right to inspect and copy information that is disclosed.

I understand that if I refuse to consent to the release of information, my medical information will not be released and denial of insurance reimbursement may occur.

I understand that I may withdraw this authorization at any time by submitting in writing a notice of revocation to Suburban Lung Associates except to the extent that action has already been taken.

Signature: ______________________ Relationship: __________ Date:__________

Age 17 or younger-parent or guardian needs to sign

I authorize ______________to pick up my medical record information in the even of unforeseen circumstances.

We will provide a patient with One Copy of their Entire Medical Records at No Charge. Any additional request will be a charge of $25.00.

WWW.SUBLUNG.COM

800 Biesterfield Road
Suite 510
Elk Grove Village, IL 60007
T 847.981.3660
F 847.956.5108

25 N Winfield Road
Suite 204
Winfield, IL 60190
T 847.981.3660
F 847.956.5108

100 Spalding Drive
Suite 200
Naperville, IL 60540
T 630.355.8776
F 630.355.7445

1614 W Central Road
Suite 105
Arlington Heights, IL 60005
T 847.818.1184
F 847.818.0980

76 Countryside Parkway
Suite A
Yorkville, IL 60560
T 630.355.8776
F 630.355.7445

24600 W 127th Street
Suite B125
Plainfield, IL 60585
T 630.355.8776
F 630.355.7445