SUBURBAN Gastroenterology, Ltd.
MIDWEST Endoscopy Center

Medical Records Number: 630-527-6450 ext 149
Medical Records Fax: 630-303-5930

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Telephone Number: _____ Social Security Number (Last 4 digitis) XXX-XX- __ __ __ __

AUTHORIZES:

Individual/Entity Name: _____

Address: _____

Phone: _____ Fax: _____

TO DISCLOSE TO:

Suburban Gastroenterology, LTD / Midwest Endoscopy Center, LLC

Attn: _____

1243 Rickert Dr. Naperville, IL 60540

Please fax records to 630-527-6456

* Records will be faxed unless box below is checked.

☐ Please mail records to address provided above.

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the records to be disclosed:

☐ Office notes ☐ Lab results ☐ Radiology reports

☐ Operative reports ☐ Pathology reports

☐ Only send the following: _____

EXPIRATION: This Authorization will expire twelve (12) months from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization at any time in writing; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) as authorized by law.

SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____

If signed by a person other than the patient, complete the following:

1. Individual is: a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

Office Use Only: Sent/Completed By: _____ **Date:** _____