

**Northwest Suburban Urology Associates, S.C.**

**Geoffery Engel, M.D. Daniel Garvey, M.D.**

**Eric J. Dybal, M.D. Joseph Oh, M.D.**

**Authorization Form for Release of Confidential Health Information**

I, \_\_\_\_\_, hereby authorize Northwest Suburban Urology Assocs., S.C.  
*(Name of Patient or Authorized Agent)*

to release to: \_\_\_\_\_  
*(Name of Health Care Facility, Physician, Agency, etc.)*

\_\_\_\_\_  
*(Street Address, City, State and Zip Code)*

the following information contained in the patient record of \_\_\_\_\_  
*(Patient's Name)*

born \_\_\_\_\_, residing at \_\_\_\_\_:  
*(Birthdate) (Street Address, City, State and Zip Code)*

<input type="checkbox"/> The entire medical record, <b>excluding</b> mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records	<input type="checkbox"/> HIV/acquired immune deficiency syndrome (AIDS) records
<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Alcoholism Treatment Records	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Drug Abuse Treatment Records	<input type="checkbox"/> Operative Notes
	<input type="checkbox"/> Other: _____

The above information for the following period of time shall be released:

From: \_\_\_\_\_ to \_\_\_\_\_.  
*(Date) (Date)*

The purpose(s) of the authorization is (are) \_\_\_\_\_

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 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 redisclosure 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. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on \_\_\_\_\_.  
*(Date)*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_.