John T. Carroll, MD
503 Thornhill Drive Carol Stream, Illinois 60188
630-653-4200 fax: 630-653-4242

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

I hereby authorize that health information regarding the above person be forwarded as indicated below:

☐ **John T. Carroll, MD to RELEASE TO:**

_____
(Name)

_____

_____
(Street address, city, state, zip code)

☐ **INFORMATION FROM:**

_____
(Name)

_____

_____
(Street address, city, state, zip code)

TO BE RELEASED TO: **John T. Carroll, MD**

The purpose of the disclosure is: _____

_____

I authorize the release of the following medical records: *(Please check appropriate boxes)*

☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Operative Notes ☐ Progress/Physician Notes ☐ Immunization Record
☐ Other, please specify _____

I authorize the release of the following confidential items *(THESE MUST BE CHECKED TO BE INCLUDED):*

☐ Behavioral or Mental Health information/records
☐ Alcohol/drug diagnosis, treatment, referral information
☐ HIV related health information/records
☐ Genetic Testing information/records

I authorize the release of the above medical records for date of service: From _____ To _____

- I understand that I have the right to inspect and receive a copy of 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 health information for disclosure to a third party.
- I understand that the 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 understand this authorization will expire in 90 days or on date shown: _____.

Signed _____ Date _____

PLEASE NOTE: There may be a charge for release of records. Please call the office for applicable fees. Rev 8/14