# SOUTHWEST INFECTIOUS DISEASE ASSOCIATES, LTD

## FAX TO 815-726-0232

### AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS

Patient Name:_____

Date of Birth:_____ Phone:_____

Address:_____

I hereby authorize Southwest Infectious Disease Associates, LTD

- ❑ Release copies of billing or medical records to the following persons or entities
- ❑ Receive copies of billing or medical records from the following persons or entities

Name and Address of person or entities to receive records:

_____

_____

The following information shall be obtained and/or released pursuant to this Authorization:

| | | | |
|---|---|---|---|
| | History and Physical | | Operative Report |
| | Pathology Report | | Radiology Report |
| | Billing Records | | Other (Specify): |
| | Entire Medical Record Set | | |

I request the the above information be released for the following date(s) of service:

_____

**NOTICE TO PATIENT/PATIENT REPRESENTATIVE:** If the recipient of the information disclosed pursuant to this Authorization is not a health care Provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

| | | | |
|---|---|---|---|
| | Treatment/Continuity of Treatment | | Legal Reasons |
| | AT THE REQUEST OF THE INDIVIDUAL | | Assessment & Evaluation |
| | Other (Specify): | | |

This authorization will automatically expire 1 year from the date it is signed unless the box below is checked and another expiration date or event is specified.

- ❑ Expiration date/event:_____

This Authorization may be revoked by notifying our office in writing at the following address:
Southwest Infectious Disease Associates, LTD
1051 Essington Road, Suite 210
Joliet, Illinois 60435
PHONE: 815-726-1818
FAX: 815-726-0232

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by our office.

_____ _____
Patient Signature Date

_____ _____
Personal Representative's Signature Date

_____
Personal Representative's Relationship/Authority

**This Authorization is voluntary. A refusal to sign will *not* affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan of eligibility for benefits.**