



# CHICAGO DIZZINESS AND HEARING

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## **INFORMED CONSENT FOR RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I authorize Chicago Dizziness and Hearing to disclose the following health information to the following party during the term of this authorization (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Physician's letters to patient and/or referring physician | <input type="checkbox"/> Physician's letters to third party               |
| <input type="checkbox"/> Progress notes  | <input type="checkbox"/> Itemized bill                                    |
| <input type="checkbox"/> Messages  | <input type="checkbox"/> Other: _____                                     |
| <input type="checkbox"/> Prescriptions   | <input type="checkbox"/> Records from third party (please specify): _____ |
| <input type="checkbox"/> Test results  |   |

For the following dates of service: \_\_\_\_\_

Recipient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

The purpose of this disclosure is: \_\_\_\_\_

*Chicago Dizziness and Hearing's obligation of confidentiality and that of Chicago Dizziness and Hearing staff is waived as to the information described and the recipient designated. Chicago Dizziness and Hearing is released from all legal liability that may arise from the requested release of this medical record information.*

*I understand that I may change my mind and revoke this authorization at any time by notifying Chicago Dizziness and Hearing in writing. The revocation will not apply to the extent that any Chicago Dizziness and Hearing staff has already taken action where it relied on my permission. I understand that once my health information is disclosed to the recipient, Chicago Dizziness and Hearing cannot guarantee that the recipient will not disclose the health information to a third party or as required by law.*

**I have read and understand this authorization and had a chance to ask questions about the disclosure of my health information in the manner described above.**

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

Personal Representative\*: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*\*The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate or other person.*