# 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 my health care information to the following party:**

Recipient: ______________________________________ Phone Number: ________________

Address: ________________________________________________________________________

Email address: ________________________________________________________________

Unless otherwise required, these records will be supplied as an encrypted PDF containing clinical notes, test results, and billing records.

*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 understand that I may refuse to sign the authorization and the refusal with not affect my ability to obtain treatment, payment or eligibility for benefits.*

**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.*