AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I hereby authorize the release of individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Address: _____

Persons/Organization(s) providing the information: _____

Persons/Organization(s) receiving the information: Advent Neurology, SC

Address: 657 E Golf Rd, Ste 304, Arlington Heights, IL 60005

Phone: (847) 640-7377 Fax: (847) 640-7977

Information to be released: (Date From:_____ to _____)

O Entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/AIDS records
O Mental health treatment records
O Alcoholism treatment records
O Drug abuse treatment records
O HIV/AIDS records
O Laboratory reports
O X-ray reports
O Other: _____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. Absent such revocation, the Authorization for Release of Confidential Health Information will terminate on _____.

Signature: _____Date: _____

Printed name _____

Relationship to the patient: _____