AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient's name:	Patient's date of birth:
Patient's address:	
Persons/organizations to receive the information, including address: Dr. Steven Miller Skokie Foot & Ankle Specialists, Ltd. 9933 Lawler Ave., Suite 315 Skokie, IL 60077	phone 847-675-3400 fax 847-725-0070
Please release the ☐ Complete Medical Record, or one or more of the following: ☐ X-rays ☐ Laboratory ☐ Operative Reports ☐ Billing and Claim Records ☐ Progress Notes ☐ Other (specify):	
This information is to be used/disclosed for the following purposes(s) only: *(you can skip this if you are the patient and do not wish to state the purpose)*	
This authorization will expire on: *(state date or event)*	
I understand that my health information to be released may include information that is related to sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus, behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I initial here. _____ (Initials)	

Form must be completed before signing. You are entitled to a copy of this document.

_____ _____

Signature of patient or patient's representative Date

If applicable: _____ _____

Printed name of patient's representative *Relationship to the patient*