

DRS BEAMER, CARLON & CRAIGEN, S.C.

1011 West Lake Street • Suite 300 • Oak Park, IL 60301

Tel. 708-628-0600 • Fax 708-628-0608

www.DoctorDivas.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, authorize the physician and/or administrative or clinical staff at

Name / Practice Name

Address

City

State

Zip

Phone Number

Fax Number

To use and/or disclose a copy of the specific health and medical information identified below for

Last Name of Patient or Minor Child

First Name

Middle Initial

____/____/____
Date of Birth (Month/Day/Year)

Send records to

Drs Beamer, Carlon & Craigen, S.C.
1011 West Lake Street, Suite 300 • Oak Park, IL 60301
708-628-0600 (Tel) • 708-628-0608 (Fax)

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or records if such information and/or records exist:

(initial) Please send the following medical records from ____/____/____ to ____/____/____
Month/Day/Year Month/Day/Year

(initial) Progress Notes

(initial) Laboratory Tests

(initial) Diagnostic Imaging

(initial) Consult Notes

(initial) Pathology Reports

(initial) Billing Statements

(initial) Other, please specify _____

(initial) HIV/AIDS related information and records

(initial) Mental Health information and/or records

(initial) Genetic testing information and/or records

Drug/alcohol diagnosis, treatment or referral information. Federal regulations require a description of how much and what kind of information is to be disclosed.

(initial) **Describe:** _____

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Michele F. Carlon, M.D.
Board Certified in Internal Medicine

Emily K. Beamer, M.D.,
Board Certified in Internal Medicine & Pediatrics

Rhea Craigen, M.D.,
Board Certified in Family Medicine

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This protected health information is being used or disclosed for the following purposes:

<u> </u> (initial)	Transfer to another facility	<u> </u> (initial)	Research stuffy
<u> </u> (initial)	Insurance Request	<u> </u> (initial)	Legal consultation (initial)
<u> </u> (initial)	Other, please specify _____ _____ _____		

I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy any information used/disclosed under this authorization. I also understand that a *fee* may be required for copies.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Office Manager/Coordinator except to the extent that action has been taken in reliance on this authorization. *Unless revoked earlier, this authorization will expire in 90 days from the date of the signing or at the end of the research study.*

Print name of patient or personal representative

Signature of patient or personal representative

____/____/____
Date (Month/Day/Year)

Description of personal representative's authority

Michele F. Carlon, M.D.
Board Certified in Internal Medicine

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Rhea Craigen, M.D.,
Board Certified in Family Medicine