

Advanced Medical & Rehabilitation, Ltd.

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150 W. Half Day Rd, Ste 205, Buffalo Grove, IL 60089
info@painmanagementchicago.com

Authorization for Disclosure of Health Information

- Name: _____
 - Date of Birth: _____ Phone: _____
 - Address: _____
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1. Direction to Release Information

I hereby authorize **Advanced Medical & Rehabilitation / Tamara Gurevich, MD** to release my protected health information (PHI) to the following physician/entity:

Recipient Physician/Clinic: _____

Address: _____

Phone: _____ Fax: _____

2. Scope of Information

Dates of Service Requested: From _____ to _____

Records to be Released (Check all that apply):

- Progress Notes
- Most Recent History & Physical
- Lab / Pathology Reports
- Consultation Reports
- Radiology Reports (Written)
- Radiology Images (CD/Film)
- Immunization Records
- **Entire Medical Record**
- Other: _____

Purpose of Disclosure: Referral/Follow-up Transfer of Care Other: _____

3. Sensitive Record Release (Required)

I understand that my medical record may contain sensitive information. **Please initial** next to the specific categories you authorize to be released:

- _____ Mental Health/Psychotherapy Records
 - _____ Substance Abuse/Alcohol Treatment Records
 - _____ HIV/AIDS Testing or Treatment Results
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4. Acknowledgments & HIPAA Rights

- **Revocation:** I may revoke this authorization at any time by notifying the releasing provider in writing. Revocation will not apply to information already disclosed.
 - **Conditions:** I understand that my treatment, payment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.
 - **Redisclosure:** I understand that once information is released, the HIPAA Privacy Rule may no longer protect the information, and the recipient may potentially re-disclose it.
 - **Expiration:** This authorization will expire **180 days** from the date of signature unless a different date or event is specified here: _____.
 - **Fees:** I understand that the releasing office may charge a reasonable, cost-based fee for copying and mailing records as permitted by state and federal law.
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5. Signature

Signature of Patient or Legal Representative:

_____ **Date:** _____

Printed Name:

Authority of Representative (e.g., Parent, Power of Attorney):
