Authorization Form for Release of Protected Health Information (PHI) to Diamond Headache Clinic Ltd

PATIENT NAME	DOB	TEL
ADDRESS		

I hereby authorize the following PHI Custodian to release the following information contained in the patient record indicated above to Diamond Headache Clinic Ltd.	
Name of PHI Custodian	
Address of Custodian	
Tel. of Custodian	Fax. of Custodian
to release to:	
Diamond Headache Clinic Ltd	1460 N Halsted St Ste 501 Chicago, IL 60642
Tel. 773-388-6390	Fax. 312-867-7101

I understand that the Protected Health Information (PHI) in my medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.		
☐ All medical records except the items explicitly indicated in limitations	☐ Alcoholism Treatment Records	☐ Laboratory Reports
☐ Records from other institutions (e.g. facilities, physicians, etc.)	☐ Drug Abuse Treatment Records	☐ X-ray Reports
☐ Mental Health Treatment Records	☐ HIV/ Acquired Immune Deficiency Syndrome (AIDS) records	☐ Operative Notes
☐ Other		
Limitations (Do not release information in my records regarding):		
The above information for the following period of time shall be released		
Date from:	Date to:	
The purpose(s) of the authorization is/are		

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization ma be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid for **one (1) year**, unless otherwise specified below. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. The written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health.

Expiration Date (if not one (1) year):

SIGNATURE OF PATIENT/ REPRESENTATIVE	DATE
PRINT NAME OF SIGNER	RELATIONSHIP