ALLEN ROSENBAUM. M.D. 3340 S. OAK PARK AVE., SUITE #304 – BERWYN, IL 60402-3483
GASTROENTEROLOGY TEL: (708) 795-9595 FAX: (708) 795-9598

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Allen Rosenbaum, M.D. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Allen Rosenbaum, M.D to use or disclose to_____ _____(Person or Entity to Receive the information) the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released,
origin of information, etc.). _____
_____
_____

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 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 may be subject to redisclosure by the recipient and may no longer be protected by law or the federal HIPAA Privacy Rule.

I understand that this authorization is valid until it expires, unless revoked before that.

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. Written revocation must be sent to the physician's office.

Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.*(Date)*

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION