



Vista Family Medicine
10961 S Kedzie Ave
Chicago, IL 60655
Ph 773-239-9100 Fax 773-239-9102

James Valek, MD
Monica Ryan, APN/CNP
Tiffany Grant, APN/CNP

AUTHORIZATION TO RELEASE HEALTH INFORMATION

The undersigned hereby authorizes Vista Family Medicine to release medical record information as specified below.

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Phone# _____ Alternate Phone # _____

I hereby authorize that the protected health information regarding the above-named person, be released from:

**Vista Family Medicine
10961 S Kedzie Ave
Chicago, IL 60655
Fax 773 239 9102**

Information to be forwarded to:

Name _____

Practice/Organization: _____

Address _____ City/State _____ Zip _____

Phone # _____ Fax # _____

Signature of patient/parent _____

Purpose or need for this Disclosure of Information: _____

Disclosure will include (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray Reports | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> EKG/EEG Report | |

Dates of Treatment from _____ **to** _____

This information will be used/disclosed for the following purpose:

Continuing Care Personal Legal

Other: _____



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I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic *expiration date will be one year* from the date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule.

I authorize the release of the following information:

- AIDS/HIV
- STDs (sexually transmitted diseases)
- DRUG/ALCOHOL ABUSE
- SEXUAL ASSAULT
- CHILD ABUSE
- DEVELOPMENTAL DISABILITIES
- BEHAVIORAL HEALTH

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release Vista Family Medicine, and its affiliates, agents and employees from any liability in connection with the release of the information contained therein.

Signature

_____	_____
Patient	Date
_____	_____
Legal Representative	Witness
_____	_____
Relationship to Patient	Relationship to Patient

We are required by law to respond to this request within 30 days of receipt of this request.

Please tell us why you are requesting your health information:

- I am remaining a Vista patient, but am seeking care from an outside physician.
- I am moving out of the area.
- My new insurance does not include Vista (name of insurance)_____
- I was dissatisfied with some aspect of Vista (describe) _____
- Other reason (please explain) _____