Law Offices Of Mark Vajdik, LLC

900 JORIE BLVD. | SUITE 10 | OAK BROOK, IL 60523 | PH (312) 883-9500 | FAX (800) 711-1941

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Social Security Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization named:

Release by:	Release to:
Facility name:	**Law Offices of Mark Vajdik, LLC**
Address:	**900 JORIE BLVD., SUITE 10**
City, State, Zip Code:	**Oak Brook, IL 60523**

Purpose of Disclosure:	**Type of Disclosure Authorized & Delivery Instructions:**
X Legal	Provide copies of records to Law Offices Of Mark Vajdik,LLC, 900 JORIE BLVD., SUITE 10, OAK BROOK, IL 60523 | PH (312) 883-9500 | FAX (800) 711-1941

Pertinent Protected Health Information Allowed to be Included:

__ Entire Medical Record for the following treatment dates: _____

__ Billing Records for the following treatment dates: _____

__ Other (specify): _____

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management/Medical Records department in accordance with HIPAA regulation 42CFR Part 2. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in health plan, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to: diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

Signature: _____ **Date:** _____

Patient (Parent or Legal Guardian)

Relationship (if other than patient): _____

A copy or fax of this authorization shall be as valid as the original