Grayslake Oral and Maxillofacial Surgery
115 Commerce Drive; Suite D
Grayslake, IL. 60030

Authorization to Disclose Protected Health Information

Name:	Date of Birth:
Address:	
City:	
Telephone Number:	

I here by authorize **GRAYSLAKE ORAL AND MAXILLOFACIAL SURGERY** to release protected health information indicated below on the above named individual to

GRAYSLAKE ORAL & MAXILLOFACIAL SURGERY
115 COMMERCE DRIVE; SUITE D
GRAYSLAKE, ILLINOIS 60030
847-548-8800 FAX 847-548-8802

For the following purpose: ⊗ Physician or Health Care Facility ☐ Legal Purposes ☐ Personal Use

Authorization to Discuss My Account: I hereby authorize the staff of Grayslake Oral Surgery to discuss appointment information, test results and financial information with the following named person(s): _____

For Treatment Date:_____and any subsequent visit date. Expiration Date or Expiration Event: DEATH OF PATIENT.
(If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire in 90 days from the signed date below.)

INFORMATION TO BE DISCLOSED:
☐ Abstract Chart(includes Face Sheet, Discharge Summary, History& physical, Consultation Reports, Operative Reports, Diagnostic Tests)
⊗ Entire medical record
⊗ History and Physical ⊗ Consultation ⊗ Operative Report ⊗ Discharge Summary
Outpatient Services:
☐ Emergency Room ⊗ Pathology Report(s) ⊗ Laboratory Results ⊗ Radiology Results
☐ Rehabilitation Services ☐ Other_____
I understand that:

- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

_____ _____ _____ _____
(Signature of patient or legal representative) (Date) (Witness Signature) (Date)

If signed by a legal representative, indicate the relationship to the patient or authority to act for patient._____
Fees/charges will comply with all laws and regulations applicable to release protected health information.
***FOR FACILITY USE:** Date received:_____ Date completed:_____ MR#_____
When applicable, the identity of the Legal Representative was verified by the documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient. ☐ Driver's License
☐ Picture ID ☐ Legal Guardian ☐ Court appointed legal guardian ☐ Power of Attorney
☐ Executor of Estate ☐ Other_____
Person/Department completing the request:_____