



AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS
(PLEASE PRINT OR TYPE)

1. I HEREBY AUTHORIZE:

BECKER FAMILY MEDICINE, SC
181 S LINCOLNWAY
NORTH AURORA, IL 60542
Phone: (630) 906-9320 Fax: (847) 787-0945

2. TO RELEASE TO:

3. **INFORMATION TO BE RELEASED:** FULL MEDICAL RECORDS LAB REPORTS X-RAY REPORTS
 OTHER (Specify) _____

4. **RECORDS FROM THE TIME PERIOD:** _____ **TO:** _____
(Specify Dates)

5. SPECIAL PERMISSION IS REQUIRED TO RELEASE OTHERWISE PRIVILEGED INFORMATION. PLEASE RELEASE RECORDS PERTAINING TO:

- Alcoholism Drug Abuse Mental Health HIV Test Results, AIDS or AIDS Disease
 Other _____

6. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

- Insurance Change Moving to new community Transferring to new MD
 Disability Determination Other _____

7. I UNDERSTAND THAT THIS AUTHORIZATION WILL BE VALID FOR ONE (1) YEAR UNLESS OTHERWISE STATED BELOW OR REVOKED THROUGH WRITTEN NOTICE TO THE MEDICAL RECORDS OFFICE. I ALSO UNDERSTAND THAT THIS INFORMATION HAS THE POTENTIAL TO BE REDISCLOSED AND AT THAT POINT MAY NO LONGER BE PROTECTED HEALTH INFORMATION.

8. PATIENT IDENTIFICATION

Name

Maiden Name

Street Address

City / State / Zip

Birth date:

Home Phone#

Work Phone #

9. SIGNATURES

SIGNATURE of Patient or Legal Guardian / **DATE**

Relationship of Guardian to Patient/Date/Time

Patient is:

- Minor Incompetent Disabled Deceased

Legal Authority: Legal Guardian Next of Kin

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives deceased patient, an adult member of the deceased patient's immediate family may qualify. A court-appointed temporary guardian may also qualify. Treatment, payment or eligibility may not be conditioned upon obtaining the patient's authorization.
A PHOTOCOPY OR FAX OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL.