**THE LAW OFFICES OF
*RONALD L. BELL & ASSOCIATES, P.C.*1113 South Milwaukee Avenue, Suite 204
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|  |  |
| --- | --- |
| PATIENT INFORMATION | Date of Birth |
| AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATIONI hereby authorize that the protected health information regarding the above-named person be forwarded: |
| FROM: |   |
| TO:(Recipient) | RONALD L. BELL & ASSOCIATES, P.C.1113 S. MILWAUKEE AVE., SUITE 204LIBERTYVILLE, IL 60048847-495-6000 / FAX: 847-495-6001 /EMAIL: ronaldbelllaw@gmail.com  |

Purpose or need for information: personal injury litigation

Disclosure will include: *(check all that apply)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Face Sheet |  History & Physical |  Laboratory Report |  Operative Report |  Itemized Bill |
|  Discharge Sumary |  Progress/Physician Notes |  X-ray/Radiology Report |  Pathology Report |  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Emergency Report |  Nurses Notes |  EKG/EMG/EEG Report |  Consultation Report |  |

Records for the period (dates) from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

 Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse

 Records of liTLV-111 or HIV testing (AIDS test) result, diagnosis and/or treatment

 Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in I year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

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Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient

(Required if Patient is not legally authorized to sign Authorization)

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Witness