CHICAGO DIZZINESS AND HEARING

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INFORMED CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize the below named party to disclose the following health information to Chicago Dizziness and Hearing during the term of this authorization (check all that apply):

- ☐ Physician's letters to patient and/or referring physician
- ☐ Progress notes
- ☐ Vestibular testing
- ☐ Lab work (blood tests)
- ☐ Radiology (including both report and CD with images):
- ☐ Audiology testing
- ☐ Medication history
- ☐ Other: _____

_____

For the following dates of service: _____

Requested from: _____ Phone Number: _____

Address: _____ Fax: _____

The purpose of this disclosure is physician review.

Chicago Dizziness and Hearing's obligation of confidentiality and that of Chicago Dizziness and Hearing staff is waived as to the information described and the recipient designated. Chicago Dizziness and Hearing is released from all legal liability that may arise from the requested release of this medical record information.

I understand that I may change my mind and revoke this authorization at any time by notifying Chicago Dizziness and Hearing in writing. The revocation will not apply to the extent that any Chicago Dizziness and Hearing staff has already taken action where it relied on my permission. I understand that once my health information is disclosed to the recipient, Chicago Dizziness and Hearing cannot guarantee that the recipient will not disclose the health information to a third party or as required by law. I understand that I may refuse to sign the authorization and the refusal with not affect my ability to obtain treatment, payment or eligibility for benefits.

I have read and understand this authorization and had a chance to ask questions about the disclosure of my health information in the manner described above.

Signature: _____ Date Signed: _____

Personal Representative*: _____ Expiration Date: _____

**The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate or other person.*

45 CFR 164.508