Nora Medical Group, S.C.

6969 North Lincoln Avenue
Lincolnwood, Illinois 60712

2913 N Commonwealth 5th Floor
Chicago, Illinois 60657

(847) 674-1200

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____

_____
Address City State Zip Code Telephone Number

To release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, prognosis, including x-ray, correspondence and/or medical records by means of mail, fax or other electronic methods. Note: ***Information and records regarding treatment of HIV have special rules that require specific authorization.***

This authorization is:

- ☐ Unlimited (all records, excluding HIV diagnosis/treatment)
- ☐ Limited to the following medical information _____
- ☐ Immunizations only
- ☐ For a specific time period from _____ to _____

I also consent to the specific release of tests for antibodies to HIV _____ initials

To: _____
Name

_____
Street Address

_____
City State Zip Code

Restrictions: Permission for further use and disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of a facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative Relationship if other than patient

_____ _____
Patient Name (PRINT) Date

_____ _____
Date of Birth Phone Number

_____ _____
Witness Name (PRINT) Witness Signature

- ☐ Patient will pick up copies
- ☐ Copies to be mailed to patient
- ☐ Copies to be mailed to: _____