

NORA MEDICAL GROUP

6969 N Lincoln Ave

Lincolnwood, IL

(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: _____