Suburban Surgical Associates, Ltd.
3340 South Oak Park Ave., Ste. #309
Berwyn, IL 60402
Suburban Metabolic Institute, LLC
Phone#: 708-484-0621 Fax#: 708-484-0250

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: **Today's Date: _____**

Name: _____Address:_____

City/State/Zip:_____ Phone #:_____

I authorize _____ to release my records to:

_____

Method of delivery: Check preferred method of delivery

__ By US mail **__Fax**

__ Call for pick up by the patient or their legal representative.

Name of person picking up the records, if other than the patient: _____

The purpose of the disclosure is:

__Continuation of Care __Personal reasons __Insurance __Other (fill in) _____

INFORMATION REQUESTED

- Please note that "all records" or incomplete treatment dates will NOT be considered specific.

__Identify Specific Dept./Physician/Location:_____

__X-Ray __Cardiac testing __Labs __Medication List __Progress Notes

__ Other_____

For Treatment dates of treatment; _____

(For example: specific date 01/25/03; range of dates Jan-July 2001)

***Page 1 and page 2 of the authorization must be completed.**

The specific type of information to be used or disclosed is as follows: *(Please check off all appropriate)*

__Information relating to the diagnosis and/or treatment of AIDS/HIV

__Drug/Alcohol Abuse diagnosis, treatment, and/or referral of information

__Information about Genetic Testing

Signatures

- I understand that I have the right to revoke this authorization at any time. I understand the revocation must be in writing and must be sent to the attention Suburban Surgical Associates, Ltd. /Suburban Metabolic Associates, LLC at 3340 S. Oak Park Ave., Ste # 309, Berwyn, IL 60402.

- I understand that this authorization will terminate in 90 days or upon the following specified date or event , whichever is shorter:

  _____or_____

  (Specified Date) *(Specified event)*

- I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by law.

- I understand I have the right to inspect and/or receive a copy of the medical information to be used or disclosed and also receive a copy of this authorization by law.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPSE STATED ABOVE.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Representative Date

(Generally required if patient is under 18 yrs. old or incompetent)