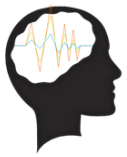

# Sinha Clinic

2560 Foxfield Road, Suite 240, St. Charles, IL 60174
Office: (630) 762-9606 | Fax: (630) 762-9605
www.SinhaClinic.com | info@sinhaclinic.com

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## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth:_____/_____/_____

Address: _____ Phone Number: (____) ___-_____

Date of Authorization: _____/_____/_____ Can we leave a message? [ ] Yes [ ] No

I, _____, hereby authorize the release of my protected health information (medical records) described below from the following provider/organization:

Name: _____ Organization: _____

Phone Number: (____) ___-_____ Address:_____

I request a copy to be transferred to/from the Sinha Clinic to use or disclose for the purpose of _____.

The type and amount of information to be used or disclosed is as follows:

____ Medication and Allergy Records
____ Progress Notes
____ Emergency room records
____ All history and physical information
____ Entire record
____ Laboratory results from _____ to _____
____ Drug and alcohol treatment
____ Psychotherapy records/ mental health records.
____ All discharge summaries & admission records.
____ Other: _____
____ Communication to listed provider/organization on patients behalf.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the **Sinha**

**Clinic (2560 Foxfield Road, Suite 240, Saint Charles, IL 60174)**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 year from date of authorization. If my initials appear here _____, I specifically authorize release of drug, alcohol abuse and/or psychiatric records. Federal law 42 CFR Part 2 prohibits those receiving information on drugs or alcohol treatment from redisclosing it unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR Part 2.

I understand that the entity or person releasing records will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. I understand that the information used to disclose as a result of this Authorization may be subjected to re-disclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state law confidentiality rules. I understand that by authorizing this release of my medical records I also release the Sinha Clinic from all legal responsibility or liability that may arise from the release of these medical records.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

A copy of this authorization shall be provided to the patient or representative when signed. Mail the completed form to: *Sinha Clinic 2560 Foxfield Road, Suite 240 Saint Charles, IL 60174* Or Fax to: *(630)762-9605*. For further questions, please contact the Sinha Clinic at (630) 762-9606.