MEDICAL AUTHORIZATION

(Pursuant to HIPAA & Applicable State Laws)

DESCRIPTION OF THE INFORMATION TO BE USED OF DICLOSED: Any and all documents, information and materials, including, but not limited to: medical. Hospital, clinic, therapeutic, chiropractic or physician's notes, records and charts; any and all medical, hospital, clinic, therapeutic, chiropractic or physician's notes, charts and reports; tests; tests results; operative reports; progress notes; x-rays, radiology reports; enhanced x-ray films (E.M.G.; C.T.; E.E.G.; MRI,, ect.); enhanced x-ray reports; consultant's evaluations, reports or records; admission and discharge summaries; doctor's orders; nurses notes; lab tests, emergency room records and reports; ambulance/ paramedic bills; where applicable, labor and delivery records and reports, pre-natal, fetal monitor strips; anesthesia records, statements for services, and any and all other information or documents, of whatever kind of description, of and pertaining to the said individual's past or present medical condition, care, treatment or rehabilitation, including, but limited to physical and mental condition, examinations made and results thereof, any and all statements of services and charges relating to the above.

IDENTIFICATION OF THE PERSON OR CLASS AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF THE PATIENT HEALTH INFORMATION (PHI):

NAME: ______________________________

ADDRESS: ______________________________

CITY/ STATE/ ZIP______________________________

DATE OF BIRTH ______________ S.S. NUMBER: ______________

IDENIFICATION OF THE PERSON OR CLASS TO WHOM THE COVERED ENITITY IS AUTHORIZED TO MAKE USE OF THE DISCLOSURE:

Advanced Physical Medicine Center, S.C.
6931 W. North Ave.
Oak Park, IL. 60302
Phone: (708) 763.0580
Fax: (708).763.0586

A DESCRIPTION OF THE PURPOSE OF THE USE OR DISCLOSURE:

Follow up medical treatment

EXPIRATION DATE OR EVENT: ______________, 20_____.

SIGNATURE OF THE INDIVIDUAL, OR THE LEGAL REPRESENATIVE, LEGAL GUARDIAN OR ADMINISTRATOR AUTHORIZED TO ACT FOR THE INDIVIDUAL:

DATE: ______________, 20_____. ______________________________

Patient/ Legal Representation/ Legal Guardian/ Authorized Signatory

A PHOTOCOPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL DOCUMENT. THIS AUTHORIZATION DOES NOT AUTHORIZE THE INDIVIDUALS OR ENTITIES TO WHICH IT IS DIRECTED TO TRANSFER OR ASSIGN THIS AUTHORIZATION TO A COMMERICIAL COPYING SERVICE WITHOUT THE EXPRESS WRITTEN CONSENTOR FEE APPROVAL OF THE PATIENT AND ATTORNEY.

THE AUTHOR OR THIS DOCUMENT MAY REVOKE THIS AUTHORIZATION IN WRITING.

THE DOCUMENTS, INFORMATION OR MATERIALS OBTAINED THROUGH THIS AUTHORIZATION MAY BE RE-DISCLOSED BY THE RECIPIENT, AND THUS, MAY NO LONGER BE PROTECTED UNDER THIS PRIVACY RULE.

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