AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Mark A. Gapinski, MD, FACOG
25 N. Winfield Road, Suite 511
Winfield, IL 60190
P) 630-462-4963 F) 630-462-0635

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

I hereby authorize that such health information regarding the above-named person be forwarded:

From: Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To: Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I authorize the release of the following medical records:

☐ Immunization Record ☐ Lab Reports ☐ Radiology Reports

☐ Operative/Delivery Notes ☐ Pathology Reports ☐ Progress/Physician Notes

☐ Other, please specify: _____

I authorize the release the above medical records from dates of service below:

_____

The purpose of this authorization is: _____

_____

_____

Please note your record preferences:

☐ Mail records (Please provide mailing address in the designated area above)

☐ Fax records (Please provide fax number in the designated area above)

☐ Hold for pick up at Dr. Gapinski's Office (Address listed at top of this form)

Requested Format:

☐ Paper

☐ Electronic (CD)

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I understand that I have the right to inspect and copy the information I have authorized to be disclosed. In the event that I refuse to authorize the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

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

I understand that this authorization gives my permission to include highly confidential health information including HIV/AIDS related health information, behavioral or mental health information, drug/alcohol diagnosis treatment and referral information and Genetic Testing information/records. Written revocation must be sent to physician's office to exclude these records.

I understand that that this authorization will expire after 90 days, unless otherwise specified at the time of signing. I also understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

I understand that this authorization will be used solely to release my health information to the above said party. This authorization cannot be duplicated or transferred.

I understand that this authorization will be used to release only my health information produced by the office of Mark A. Gapinski, 25 N. Winfield Road, Suite 511, Winfield, IL 60190. Any medical records obtained previously from another facility will not be transferred with this authorization.

Patient / Personal Representative's Signature _____

Relationship to Patient _____ **Date** _____

Witness Signature (Required) _____