Kohn Medical Group

5404 W Elm St, Ste Q McHenry, IL 60050
Phone: 815-344-7951 Fax: 815-759-3807

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (PLEASE PRINT)

LAST NAME	*FIRST NAME*	*MI*	*DATE OF BIRTH*
ADDRESS			
HOME PHONE	*CELL PHONE*	*EMAIL*	

RELEASE FROM:

☐ Kohn Medical Group

☐ Name: _____

ADDRESS	
PHONE	*FAX*

RELEASE TO:

☐ Kohn Medical Group

☐ Name: _____

ADDRESS	
PHONE	*FAX*

PURPOSE:

☐ Patient's Request ☐ Continuing Treatment

☐ Legal ☐ Insurance ☐ Other:_____

DATES OF RECORDS TO BE RELEASED:

From _____ /_____/_____ To _____ /_____ /_____

OR ☐ Release All Dates of Records

SPECIFY RECORDS TO BE RELEASED:

☐ Clinical Notes ☐ Medical History ☐ Hospitalizations ☐ Summary of Medications

☐ NeuroPsych Testing ☐ Laboratory Results ☐ EEG Results ☐ Sleep Study Results

☐ Imaging Results (MRI, CT, XRay, SPECT) ☐ Other (Specify): _____

☐ Entire Health Record (Fees may apply. There is no charge to mail health record to another healthcare professional e.g. physician)

By INITIALING below, I am authorizing the release of the following information:

Initials_____ ALCOHOL and/or DRUG ABUSE treatment information (as protected under 42 CFR)

Initials_____ HIV/AIDS Information (as defined by Illinois Statute)

Initials_____ MENTAL HEALTH Records (as defined by the Illinois Mental Health and Developmental Disabilities Confidentiality Act)

Initials_____ TWO-WAY RELEASE (to include permission to discuss, in person or by telephone, the above released information)

This consent will terminate upon (specific date): ___MONTH___ ___DAY___ ___YEAR___. I understand that I may revoke this consent at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
If no calendar date is specified above, Mental Health Records may only be released on the date this release is received by our office.

NOTICE TO PATIENT:
"I fully understand that my medical record and health Information for the above date(s) may contain alcohol/drug abuse, and/or HIV/AIDS test results, mental health information and/or other information." I understand that any of the above selected records may contain medical information from outside sources and authorize Kohn Medical Group to release these records for continuity of care or if I have requested my complete record. I understand that I have the right to inspect and/or obtain a copy (for the appropriate fee) of my medical record prior to disclosure. I understand that this consent applies both to written and verbal release of information. I understand that I am under no obligation to sign this authorization to release my medical information. I absolve, discharge, release, and hold harmless the Kohn Medical Group together with its agents and employees for any legal liability, claims, or damages which may arise from the disclosure of this Information. **To receiving Agency: These records may not be re-disclosed without the patient's consent.**

_____ _____

Signature of Patient / Power of Attorney or parent / legal guardian if Patient is a Minor *Date*

_____

Relationship to Patient, if signed by parent / authorized representative

_____ _____

Signature of Minor Patient, if 12 to 17 years of age *Date*

_____ _____

Witness Signature (required for Mental Health / HIV/AIDS / Substance Abuse) *Date*