RAVENSWOOD
RHEUMATOLOGY

Manish Jain, MD
1945 W. Wilson Avenue, Suite 100, Chicago, IL 60640
Tel: 773-769-9040 | Fax: 847-866-8990
www.RavenswoodMD.com

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____
Dr.'s Address: _____
_____

to release the following information from the health records of:

_____ _____
(Print patient name) (DOB)

_____
(Patient address) (City, State, Zip)
Social Security Number: _____

Information to be released to: _____
Address: _____
_____
Purpose of disclosure: _____

*******I authorize the release of any and all medical records and reports concerning my medical history, physical condition, diagnosis, treatment and/or prognosis, including x-rays and other diagnostic reports, as well as any information contained in my medical records or reports that relates to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous communicable diseases, including AIDS or tests for infections with HIV, and any other information related to my treatment.

This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows:

Information to be released:

_____ Copy of complete health record(s) _____ Bone density report(s)
_____ History and Physical _____ X-Ray report(s)
_____ Other _____ _____ Lab report(s)

Do not release information contained in my record regarding: _____
_____

Release only my records for the dates of _____ through _____.

I understand this consent can be revoked in writing at any time to Ravenswood Rheumatology except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

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 federal or state law.

Ravenswood Rheumatology will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to 1) Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), 2) Refuse to sign this authorization, 3) Receive a signed copy of this authorization.

This authorization is valid for sixty (60) days after the date this request is made and/or for the length of the pending claim, unless otherwise stated as follows _____

Patient's Signature_____Date_____
(Or signature of legal representative if patient is a minor or incompetent)