REQUEST FOR MEDICAL RECORDS BY
GRANDVIEW HEALTH PARTNERS, LTD.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Address: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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

From: Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

To: (Recipient) Grandview Health Partners, Ltd.

201 W. Lake St. Ste. 359. Chicago, 1L60606

Phone: (773) 525-5900 Fax: (773) 585-5980

Disclosure will include:

☐ All Records ☐ Face Sheet ☐ History 8c Physical ☐ Laboratory Report ☐ M RI/CT/X-ray Report

☐ MRI/CT/X-ray FILMS ☐ Discharge Summary ☐ Progress Notes ☐ Operative Report

☐ Pathology Report ☐ Any Not Listed ☐ _____

RECORDS FOR THE PERIOD (DATES) FROM: _____

I may check one or more of the following types of health information that I do not want released to the above name Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

☐ Diagnosis, Evaluation and / or treatment for alcohol and or drug abuse

☐ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

☐ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, psychiatric examination, progress notes, consultations, treatment plans / evaluation

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid sinless revoked but will expire in 1 year after signing, I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, this institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent / Legal Guardian / Personal Representative
(Required if Patient is not legally authorized to sign Authorization)

Relationship to Patient

_____

Witness

DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that this clinic cannot guarantee that the Recipient receiving the requested health information will not disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the disclosure of any health information, drug and/or alcohol abuse, HIV and mental health treatment.