Midwest Digestive Health and Nutrition
900 Rand Road Suite 120
Des Plaines, IL 60016
Phone: 312-767-3244
Fax: 708-795-9598

Request and Authorization to Release Health Information

Use this form to request a copy of your medical records from Midwest Digestive Health and Nutrition. In order for MDHN to respond promptly and accurately to your authorization, please complete this form in its entirety.

Patient Name Last	First	Middle initial

Date of Birth			**Today's Date**		
Month	Date	Year	Month	Date	Year

Address	City	State	Zip	Phone

INFORMATION REQUESTED: I authorize Midwest Digestive Health and Nutrition to use or disclose the following information during the term of this Authorization. **Check all that apply.**

☐ Clinic Visit Notes ☐ Endoscopy Reports ☐ Pathology Reports ☐ Laboratory Results	Radiology Images ☐ CT ☐ MRI ☐ Ultrasound	☐ Other (please specify) _____

For The Following Dates of Treatment: ☐ Specific dates: _____ ☐ All dates

RECIPIENT: Delivery details – to you or to the person/company (i.e.: physician, insurance company, school)

Delivery method	☐ Fax: _____	*Charges apply to all printed copies* *$25 for limited copying/$35 full chart* ☐ Pick up in person ☐ US Mail

Send to: Name				
Address	City	State	Zip	Phone

The purpose of the copy (disclosure) is:	☐ Personal use	☐ Sharing with healthcare provider	☐ Other (please specify)

TERM: Unless a box below is checked, this authorization will expire when the request is fulfilled.

- ☐ From the date of this Authorization until: _____
- ☐ Until the following event occurs: _____
- ☐ Other (please specify): _____

Midwest Digestive Health and Nutrition
900 Rand Road Suite 120
Des Plaines, IL 60016
Phone: 312-767-3244
Fax: 708-795-9598

Request and Authorization to Release Health Information

Patient Name		
Last	First	Middle

SPECIFIC CONSENT SECTION: Please note if the below is not completed, this information will not be released

Check any or all of the boxes below to authorize this information to be used or disclosed with your record.
Information about:

- ☐ Mental illness or developmental delay
- ☐ HIV/AIDS testing or treatment (including fact that an HIV test was ordered, performed, or reported, regardless of whether the results of these tests were positive or negative)
- ☐ Communicable diseases
- ☐ Sexually transmitted infections
- ☐ Substance (i.e., alcohol or drug) abuse
- ☐ Abuse of an adult with a disability
- ☐ Sexual assault
- ☐ Child abuse and neglect
- ☐ Genetic testing
- ☐ Artificial insemination
- ☐ Psychotherapy notes (which are not part of the official medical record)
- ☐ All the above (By checking this box, I am indicating that I have reviewed the entire list above and authorize the use and disclose of all related confidential information in the manner described in this Authorization)

I understand that I may revoke this authorization at any time by notifying MDHN in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by MDHN before receiving my revocation.
I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
I understand that I have the right to inspect or copy any information used/disclosed under the authorization. I understand that once my health information is disclosed to the recipient MDHN cannot guarantee that the recipient will not redisclose the health information to the third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.
I understand that MDHN may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that MDHN will not provide such research-related treatment unless I provide this authorization.
I have read and understand the terms of this Authorization and I have had the chance to ask questions about the use and disclose of the health information. I authorize MDHN to use or disclose my health information in the manner described in this Authorization.

Signature of Patient	**Date**

FOR PERSONAL REPRESENTATIVES OF THE PATIENT	
Name of Personal Representative	*Relationship of Patient*
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.	
Signature of Personal Representative	***Date***