M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

1509 N. Western Ave, Unit-A
Chicago, IL 60622
T: (773) 227-3303
F: (312) 575-3507
www.mchavezmd.com

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Phone: _____

Address: _____ City/State/Zip: _____

I authorize the following healthcare facility to disclose/release the information indicated below:

Facility Name: _____ Facility Phone: _____

Facility Fax: _____

Facility Address: _____ City/State/Zip: _____

- ☐ All records
- ☐ Laboratory and pathology records
- ☐ X-Ray/radiology records
- ☐ Billing records
- ☐ Abstract/summary
- ☐ Pharmacy/prescription records
- ☐ Other (please describe specifically): _____

Note: If these records contain information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

The records are for services provided on the following date(s): _____

Please send the records listed above to:
M. Chávez, MD, SC
1509 N Western Ave. Unit – A; Chicago, IL 60622
T: (773) 227-3303
F: (773) 897-5848

The information may be used/disclosed for the following purposes:

- ☐ At my request
- ☐ For my healthcare
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: _____ _____

This authorization shall expire no later than ___ / ____ / ____ or upon the following event _____ (whichever is sooner), and will expire one year from date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign it will not affect my ability to receive treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient (Or Patient's Personal representative) Date

_____ _____
Printed Name of Patient Representative Representative's authority to sign for patient

You have the right to revoke this authorization, except to the consent the custodian of the records has relied on it, by sending your written request to 1509 N. Western Ave, Unit - A, Chicago, IL 60622
A copy of the signed authorization must be given to the individual.