Patient Name: _____
Address: _____
Phone Number: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

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

FROM: **Person/Institution: _____**
Address_____
City: _____State: ____Zip Code: _____ Phone: _____Fax: _____

TO: Person/Institution: **Nava Segall**
Address **4116 N. Lincoln**
City **Chicago** State **IL** Zip Code **60618** Phone: **773-883-2350** Fax: **773-883-2351**

Purpose or need of information: _____

What is being authorized for release?
Please check and initial the specific protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization).

☐ General Medical	Initial_____	☐ Genetic Testing	Initial _____
☐ Mental Health	Initial _____	☐ HIV/AIDS	Initial _____
☐ Alcohol/Substance Abuse	Initial _____	☐ Physician Name/Dept. of Service	Initial _____

Other (Please specify):_____

I must check one of more of the following types of health information that I do not want released to the above named 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 of evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans. And/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact at this site of care except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked by 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, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Parent/Legal Guardian/personal Representative **Relationship to Patient**
(Required if Patient is not legally authorized to sign Authorization)

REDISCLOSURE:Notice is hereby given to the patient or legal representative signing this Authorization that Nava Segall M.D.S.C. cannot guarantee that the recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.