AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: ______________________________

I hereby authorize the use and/or disclosure of protected health information about me as described below.

1. Description of protected health information that may be used and/or disclosed:
   • ***Medical records, x-rays, billing/account information.***

2. The name/class of persons authorized to make/receive the requested use and/or disclosure:

   ____

   ____

3. This protected health information is being used or disclosed for the following purposes:
   • ***Treatment, payment, other healthcare operations.***

4. This authorization shall be in force and effect until the following date or event, at which time this authorization to use or disclose this protected health information expires.

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5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Lu, Privacy Officer, or Jamie, Assistant PO, 406 N. Front Street, Suite A, McHenry, IL 60050. I understand that a revocation is not effective to the extent that John A. Elstrom, M.D., Robert F. Hall, Jr., M.D. and Albi Qeli, M.D. have relied on the use or disclosure of the protected health information.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. I understand that I may refuse to sign this authorization and that John A. Elstrom, M.D., Robert F. Hall, Jr., M.D. and Albi Qeli, M.D. will not condition my treatment on whether I provide authorization for the requested use or disclosure.

______________________________	______________________________
Signature of Patient or Personal Representative	Date
______________________________	______________________________
Name of Patient or Personal Representative	Relationship of Personal Representative To Patient (if applicable)

(A copy of this signed form will be provided to the patient upon request.)