PARAG B. THAKKAR, MD, SC
1170 E. BELVIDERE ROAD, SUITE 210 GRAYSLAKE, IL 60030
PHONE: 847-548-9186 • FAX: 847-548-1356

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____ **Date of Birth:**_____
(First Name) (Middle Initial) (Last Name)

Address:_____

Parag B. Thakkar, MD SC is authorized to **disclose to / receive from** (circle desired choice):

Recipient/Discloser: _____

Address: _____

_____

For the Purpose of : _____
(optional)

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:
  All medical records for last 2 years including history and physical, clinic notes, laboratory studies, radiology reports, consultation notes, **AND** most recent EKG/stress tests/echocardiogram report, EGD/colonoscopy report, all adult immunization record.

- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

  _____

I release Parag B. Thakkar, MD SC., and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Parag B. Thakkar, MD SC., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date

If transferring care to another provider, please let us know the reason so that we may improve our patient care (check all that apply):

- ❑ Not satisfied with Doctor/Provider
- ❑ Not satisfied with Staff (which staff member? _____)
- ❑ Moving out of the area?
- ❑ Other (Please describe :_____)