Colette Gordon, M.D and Associates

2800 N Sheridan Road Suite 101
Chicago, IL 60657
Tel 773-281-7835 Fax 773-281-8736
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Authorization to release/disclose health information

I hereby authorize ____
To release or disclose the following protected health information from the medical records of the patient listed below:

Name: ______________________________

DOB: ______________________________

SSN: ______________________________

Address: ______________________________

Requestor name: **Colette Gordon, M.D and Associates**
Requestor address: **2800 N Sheridan Road Suite 101**
Chicago, IL 60657

Disclose the following protected health information for treatment dates ______ to _____

- ☐ Emergency Room Report
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Labs/Imaging/ Procedure
- ☐ Discharge Summery
- ☐ Entire Chart
- ☐ Consult Notes
- ☐ Operative Reports

The above information is disclosed for the following purpose: **Medical Care**

I acknowledge and hereby consent to such that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to____
I understand that the revocation will not apply to information that has already been released to this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

____
Signature of the Patient/Legal Representative

____
Date

If signed by a Legal Representative, relationship to patient: ______________________

____
Witness Signature

____
Date

PLEASE MAIL IF GREATER THAN 10 PAGES