Chicagoland Oculoplastics Consultants

940 Lee Street, Suite 200, Des Plaines, IL 60016
360 W. Butterfield Rd, Suite 200, Elmhurst, IL 60126
1555 N Barrington Rd., DOB 1, Suite 330, Hoffman Estates, IL 60169

Phone: 224-567-8480 Fax: 847-813-6426

Kathryn P. WInkler, MD
Stephen J. Winkler, MD

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**SECTION 1: PATIENT INFORMATION** (please print and complete all fields)

First Name _____ Last Name _____ Date of Birth _____

Address _____ City/State/Zip _____ Phone _____

**SECTION 2: INFORMATION REQUESTED**

DR. WINKLER may use or disclose the following health care information:

- ☐ All my health information maintained by you
- ☐ My health information relating to the following treatment or condition:
  _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

**SECTION 3: I authorize Chicagoland Oculoplastics Consultants to release the above patient records to:**

Name of individual/organization _____ Phone _____

Address _____ City/State/Zip _____ Fax _____

**SECTION 4: Purpose of Disclosure**

☐ Continuation of care ☐ Personal Reasons ☐ Insurance ☐ Legal

☐ Transfer of care (permanently leaving) ☐ Other: _____

**SECTION 5: Method of delivery**

☐ Fax ☐ U.S. mail ☐ In person

**SECTION 6: Signature(s)**

- I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form
  - o To take part in a research study; or
  - o To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization at any time, in writing, sent to Dr. Winkler at 940 Lee St. Des Plaine, IL 60016If I do, it will not affect any actions already taken by Dr. Winkler based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.
- I understand this authorization will expire in 90 days of upon the following specific date_____ or event_____.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.

Patient signature: _____ Date: _____

Representative signature: _____ Relationship:_____

Witness signature: _____ Date: _____

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## SPECIAL CIRCUMSTANCES

### Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

Patient signature: _____ Date: _____

### Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

Patient signature: _____ Date: _____