Pfeiffer Medical Center
3S721 West Street, Suite 300
Warrenville, IL 60555
(630) 505-0300 Fax (630) 836-0667

Authorization for Release of Information to Third Party

_____ _____
Patient Name Date of Birth

If you are 18 years or older, you have the right to refuse or allow all, part or none of your protected health information to be released.

_____ I do not authorize information to be released to a family member or caregiver.

_____ I do authorize the release of all or part of my protected health information to be communicated to a family member or caregiver. I have identified the person(s) who I am authorizing to release information and the protected health information to be released:

____ Lab Results ____ Treatment Information
____ Billing ____ Other (please explain) _____

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

If this request is by a personal representative on behalf of the patient, please complete the following:
Personal Representative's Name (please print):_____
Personal Representative's Signature: _____
Relationship to Patient: _____

Authorization Expiration: This authorization will expire one (1) year from date of patient signature unless otherwise indicated. _____

Patient Signature_____Date_____

Please note: This authorization is voluntary. We will not condition your treatment on giving this authorization.