ADVANCED INTERNAL MEDICINE
of NORTHERN ILLINOIS

Patient:_____
(First Name) (Middle Initial) (Last Name)

Address:_____

City State Zip: _____ **Date of Birth:**_____

ADVANCED INTERNAL MEDICINE of NORTHERN ILLINOIS (AIMNI) is authorized to **furnish to / receive from** (circle desired choice):

Name: _____

Address _____

Phone/Fax: _____

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, STI, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, if any.
- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release AIMNI, 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 AIMNI 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

So that we may improve our patient care, please let us know the reason you are requesting this record release

- ❑ Not satisfied with Provider (which provider? _____)
- ❑ Not satisfied with Staff (which staff member? _____)
- ❑ Other (Please describe:_____)