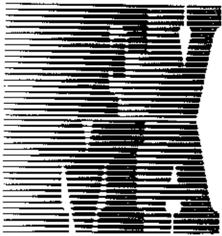


FOX VALLEY MEDICAL ASSOCIATES, LTD.

INTERNAL MEDICINE

Nephrology

Harry Rubinstein, M.D.
Aurora 851-1144
Batavia 879-5700

Pardeep Sood, M.D.
Aurora 851-1144
Batavia 879-5700

Valerie Heidenry, M.D.
Aurora 851-1144
Batavia 879-5700

Rasa Kedainis, M.D.
Aurora 851-1144
Batavia 879-5700

Ivan Begov, M. D.
Aurora 851-1144
Batavia 879-5700

Infectious Diseases

Bob Manam, M.D.
Aurora 851-1144

Harkamal Rehal, M.D.
Aurora 851-1144

Erin Stillwell, P.A. - C
Aurora 851-1144

GENERAL INTERNAL MEDICINE

Philip Branshaw, M.D.
Batavia 879-5700

FAMILY PRACTICE

Mark J. Bernhard, M.D.
Batavia 879-5700

Sergio Mercado, M.D.
Batavia 879-5700

LOCATIONS

2020 Ogden Ave.
Suite 140
Aurora, IL 60504
Ph: (630) 851-114

Fax: (630) 851-8837

1180 W. Wilson St.
Suite E
Batavia, IL 60510
Ph: (630) 879-5700

Fax: (630-879-6457

www.foxvalleymedical.com

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

1. MY INFORMATION:

Patient Name:	Address:
Phone: Fax:	City: State: Zip:
E-mal Address:	Date of Birth: Last 4 SS#:

2. CUSTODIAN INFO: I hereby give the following entity permission to release my Protected Health Information (PHI):

Name:	Address:
Phone: Fax:	City: State: Zip:

3. INFORMATION REQUESTED: I instruct the above entity to release a copy of the following information (Check One):

___Comprehensive Care Summary (Covering 24 months) ___ Entire Record
___Specific Records:

4. WHERE TO SEND: I am requesting the above designated records be released to the following entity or person:

Name:	Address:
Phone: Fax:	City: State: Zip:

5. FORM AND FORMAT OF RECORDS: I request the copies of records be delivered as follows (Check one):

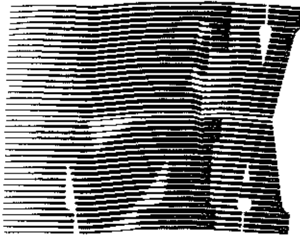
√	Form	Format	Method of Delivery
	Electronic	PDF	*E-mail records to:
	Electronic	FAX	Fax records to the number indicated above
	Electronic	PDF	Download – E-mail a secure link to:
	Hard Copy	Paper	Mail to the address indicated above

**E-mailed records sent to an unencrypted e-mail address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving your records via e-mail to the address you specify.*

6. REASON FOR DISCLOSURE: I am requesting my PHI to be disclosed for the following purpose:____

7. SENSITIVE INFORMATION DISCLOSURE: HIV, behavioral health, or drug and alcohol abuse/treatment information within the dates specified above *are to be released through this authorization* unless otherwise checked below:

DO NOT RELEASE: (Check all that apply) ___HIV ___ Behavioral Health
___Drug/Alcohol



FOX VALLEY
MEDICAL
ASSOCIATES, LTD.

INTERNAL MEDICINE

Nephrology

Harry Rubinstein, M.D.
Aurora 851-1144
Batavia 879-5700

Pardeep Sood, M.D.
Aurora 851-1144
Batavia 879-5700

Valerie Heiderry, M.D.
Aurora 851-1144
Batavia 879-5700

Rasa Kedainis, M.D.
Aurora 851-1144
Batavia 879-5700

Ivan Begov, M. D.
Aurora 851-1144
Batavia 879-5700

Infectious Diseases

Bob Manam, M.D.
Aurora 851-1144

Harkamal Rehal, M.D.
Aurora 851-1144

Erin Stillwell, P.A.-C
Aurora 851-1144

GENERAL INTERNAL MEDICINE

Philip Branshaw, M.D.
Batavia 879-5700

FAMILY PRACTICE

Mark J. Bernhard, M.D.
Batavia 879-5700

Sergio Mercado, M.D.
Batavia 879-5700

LOCATIONS

2020 Ogden Ave.
Suite 140
Aurora, IL 60504
Ph: (630) 851-114

Fax: (630) 851-8837

1180 W. Wilson St.
Suite E
Batavia, IL 60510
Ph: (630) 879-5700

Fax: (630-879-6457

www.foxvalleymedical.com

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

<u>This authorization is valid for 90 days.</u> I may revoke this authorization at any time by mailing o personally delivering a signed, written notice of revocation to the healthcare provider at whicl this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Parent/Guardian or Date
Personal Representative (attach proper documentation)