MIDWEST PLASTIC SURGERY INSTITUTE, INC.
3800 Highland Avenue, Suite 106, Downers Grove, Illinois 60515

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____ DOB: _____ Phone No: _____

Midwest Plastic Surgery Medical Record/Chart Number: _____

Address: _____

I hereby authorize Dr. Sandeep S. Jejurikar and Midwest Plastic Surgery Institute, Inc. to release the protected health information of the person named above to:

Person/Institution: Records Deposition Service

Address: P.O. Box 5054, Southfield, MI 48086-5054 P 248.357.3330 F 248.357.3337 email requests@recdep.com

Purpose for Request: legal - discovery before trial

Disclosure Will Include: (Check all that apply)

_____ Face Sheet _____ History and Physical _____ Laboratory Reports _____ Operative Reports _____ Bills

_____ Physician Notes _____ Prescriptions _____ Pathology Reports _____ EKG/EMG/EEG Reports

_____ X-ray/Radiology Reports _____ Photographs _____ Physician Assistant Notes _____ Patient Messages

_____ Other Documentation Provided by Patient to Doctor and/or Practice _____ Orders

_____ Physical and/or Occupational Therapy Reports _____ All Other Records In Patient File

Records For The Period (Dates) From: _____ To: _____

I must check one or more of the following types of health information that I do NOT want released to the above named Recipient. I understand that if I do not check any of the following types of records, the health information will be released to the named Recipient and may include the following:

_____ Diagnosis, Evaluation, and/or treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV Testing (AIDS Test) result, diagnosis, and/or treatment

_____ Records of other communicable and/or non-communicable diseases

_____ Records of Genetic Testing and/or Genetic Information

_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations treatment plans, and/or evaluations.

I understand that this Authorization may be withdrawn by me at any time in writing to Dr. Jejurikar at the office of Midwest Plastic Surgery Institute, Inc. except to the extent that action has already been taken to release the information. This Authorization shall remain valid unless revoked but <u>will expire in 1 year after signing</u>. I have a right to inspect a copy of the health information to be released. Midwest Plastic Surgery Institute will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient If Applicable | Date

Witness Signature: _____

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Midwest Plastic Surgery Institute, Inc. cannot guarantee the Recipient receiving the requested health information will not disclose any or all of it to others. Notice is hereby given to the Recipient law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.