



EXHALE SINUS
TMJ | HEADACHE | SLEEP

814 E Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

PATIENT REGISTRATION

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ PHONE: _____
CITY/STATE/ZIP: _____

This information is to be release:

FROM

PERSON/FACILITY: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____
FAX: _____

TO

PERSON/FACILITY: Exhale Sinus and Facial Pain Center
ADDRESS: 814 E Woodfield Rd.
CITY/STATE/ZIP: Schaumburg, IL 60173
PHONE: 773-234-5880
FAX/E-mail: 708-273-5332
info@exhalesinus.com

INFORMATION TO BE DISCLOSED:

☐ Copy of all health records. ☐ Billing Records
☐ SPECIFIC RECORDS:
Laboratory Tests _____ X-Ray Reports _____
Progress Notes _____ Other _____

THE PURPOSE OF THIS DISCLOSURE IS FOR:

☐ Continuance of Medical care.
☐ Attorney
☐ Insurance
☐ Other _____

☐ Records to be faxed or electronically transmitted?

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying medical records if used for reasons other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

Signature of Patient/Legally Authorized Representative

Date