

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HEALTH INFORMATION**

I authorize
The Bleeding & Clotting Disorders Institute & Michael D. Tarantino, M.D. S.C.
6811 N. Knoxville Ave., Suite A, Peoria, IL 61614

for the purposes of continuity of care, research and/or request of patient, to release to, or obtain from the following:

Please list all of your doctors. Also, please list family members, friends, schools, daycares, and others to whom you want us to release your information.

Name _____
Address _____

Phone _____

Name _____
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the following information contained in the patient record. The information for the following period of time shall be released:

From _____ to _____
(Date) (Date)(normally one year)

(CONTINUED ON BACK OF PAGE)

(CONTINUED FROM FRONT OF PAGE)

____ Consultations ____ Current Medications List ____ Lab Reports ____ History & Physical
____ Diagnosis ____ Other (Please list) _____
____ Entire Medical Record (excluding psychotherapy notes without a separate written release relating to this information.)

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the Institute may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party or research.

I understand that, except as noted below, information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that, except to the extent it has already been relied on, I may revoke this authorization at any time by giving written notice to the Institute of my desire to do so. Written revocation must be sent to the Institute. Absent such written revocation, this Authorization for Release of Confidential Health information will terminate on _____.

(Date - One Year Suggested)

I acknowledge that I may request a copy of this authorization.

I acknowledge that data to be released MAY INCLUDE material that is protected by State or Federal Law and this is applicable to any Mental Health Information, Drug/Alcohol Abuse or HIV/AIDS information. My signature below authorizes the release of all such information as specified above to the entities indicated on the front of this page.

Date of Birth Print Patient's Name Witness

Signature of Patient or Guardian Relationship Date

I also authorize Michael D. Tarantino, M.D. S.C. & The Bleeding & Clotting Disorders Institute, 6811 N. Knoxville Ave., Suite A, Peoria, IL 61614 to release to the providers listed on the front page of this Authorization for Release of Confidential Health Information, all information relative to any genetic testing I have had or will have, for diagnostic/ treatment purposes during the period of time indicated on the front page.

I understand that my records may be protected under the State or Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. I also understand that I may revoke this authorization at any time. I understand that I have the right to inspect the information that I have authorized to be disclosed.

Signature of Patient or Guardian Witness

I acknowledge that data to be released INCLUDES material that may be protected by State or Federal Law applicable to Genetic Testing information. My signature authorized the release of all such information as specified above.

NOTICE TO RECEIVING PARTY/AGENCY: No records or information from such records which are within the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, or under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, under the Illinois AIDS Confidentiality Act or under the Illinois Genetic Confidentiality Act may be further disclosed unless the person who consented to this disclosure specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information is not sufficient for this purpose.