LOTSU DIGESTIVE
HEALTH & NUTRITION

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Name:	Date of Birth:
Address (street, city, state, zip):	

I authorize my healthcare to be released to the following recipient:
NAME: Lotsu Digestive Health and Nutrition Center ADDRESS: 840 W Adams Street
PHONE: 312-929-3140 FAX: 312-496-3272

Purpose of the release:

□ Continuing care	□ Transfer of care	□ Social Security appeal
□ Insurance application*	□ Personal use or review*	□ Social Security disability*
□ Insurance payment/claim	□ Litigation/legal*	□ Other*

INFORMATION TO BE RELEASED

□ Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report. Discharge Summary

□ Billing Records	□ Copies of Films/Images	□ Community Pharmacy charges

Only record type(s) checked below:

□ Discharge summary/note	□ Radiology reports	□ Emergency record(s)	□ Medication records
□ History and Physical exam	□Immunization/allergy record	□ Operative Report	□ Laboratory Reports
□ Pathology Reports	□ Consultations	□ Progress Notes/ Clinic Notes	□ Pathology slides/blocks

□ Other record:

•This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:
•This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Lotsu Digestive Health & Nutrition Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.
•Lotsu Digestive Health & Nutrition Center will not restrict my treatment if I choose not to sign this authorization.
•A photocopy/fax of this authorization will be treated in the same way as an original.
•Lotsu Digestive Health & Nutrition Center records may include records that it received from other organizations. If these records have been used by Lotsu Digestive Health & Nutrition Center and filed in the record Lotsu Digestive Health & Nutrition Center maintains about you, these records may be released with your Lotsu Digestive Health & Nutrition Center records.
• Lotsu Digestive Health & Nutrition Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be

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<table>
<tr><td colspan="2">covered by state and federal privacy protections after it is released. By signing this authorization, you release Lotsu Digestive Health & Nutrition Center from all liability resulting from a redisclosure by the recipient.
•Your signature indicates that you have read and understand this form and authorize release of your information as described above.</td></tr>
<tr><td>Patient Signature:</td><td>Date:</td></tr>
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