

Abdallah Karam, M.D., S.C.
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, Illinois 60005
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MEDICAL RECORD RELEASE FORM FOR DR. KARAM

I, _____, authorize _____
(physician or healthcare facility)

to release the patient record(s) of _____ to Dr. Abdallah Karam.

Patient - Subject of the Record(s)

Address: _____

Phone: _____ Date of Birth _____

Prior Physician or Healthcare Facility - Record Holder

Address: _____

Phone: _____ Fax: _____

I authorize the release of:

_____ The entire medical record, excluding alcoholism treatment, drug abuse treatment, mental health treatment, and HIV/AIDS records.

Please check off and sign or initial the items listed below that you wish to authorize additional disclosure of conditions:

_____ Alcoholism Treatment Record *(signature required)* _____

_____ Drug Abuse Treatment Record *(signature required)* _____

_____ Mental Health Treatment Records *(signature required)* _____

_____ HIV/AIDS Records *(signature required)* _____

_____ Laboratory Reports _____ Operative/Pathology Records _____ X-Ray, MRI, CT, PET Reports

_____ Other: _____

The purpose of this authorization is _____.

I understand that:

- Under this authorization I have a right to inspect and copy information that is being disclosed or used. I also understand that if I refuse to authorize the release of any information it will not be disclosed or used unless mandated by law.
- Information that is disclosed or used with this authorization may be subject to redisclosure and therefore may no longer be protected by law.
- Treatment will not be conditioned on whether I sign this authorization. The exception would be if condition of care were for creating personal health information for a third party.
- I may revoke this authorization at any time by giving written notice to the above office address and Privacy Contact: Practice Manager of Dr. Abdallah Karam.

This authorization is valid from _____ until _____ at which time it will terminate.

Signature: _____ **Date:** _____

If you are not the patient, please specify your relationship to the patient. _____