CHMG Chicago Health Medical Group

Authorization for Release of Confidential Medical Information

I, _____, DOB _____ authorize the staff of
Print Name
Chicago Health Medical Group to coordinate the release of confidential medical information in the following manner:

Chicago Health Medical Group may leave messages on my home answering machine related to recent test results.	YES	NO
Chicago Health Medical Group may leave messages on my home answering machine related to upcoming appointments and/or scheduling issues with future appointments.	YES	NO
Chicago Health Medical Group may contact me using an automated phone messaging system for purposes of billing and/or insurance follow up.	YES	NO
Chicago Health Medical Group may contact me using an automated phone messaging system for purposes of appointment follow up or rescheduling.	YES	NO

Please list any family members or others whom may be involved in coordinating your care or payment for care. Also, please indicate what kind of information may be shared with each individual.

Name	Relationship	All	Scheduling/ Appointments	Medical	Billing/ Insurance
_____	_____	___	___	___	___
_____	_____	___	___	___	___
_____	_____	___	___	___	___

We will continue to rely on the information on this form when communicating with you and your family members or others involved in your care unless you request changes. Please promptly notify your physician office if you wish to alter designations as outlined above.

Signature of Patient/Guardian/
Legal Representative: _____ Date: _____