Advance Midwest Medical, S.C.
Rajiv K. Sood, MD

1585 N. Barrington Road
Doctors Bldg. 2 – Suite 501
Hoffman Estates, IL 60169-5020
Tel: 847.490.8900 Fax: 847.490.8999

Medical Release of Information

Patient Name:_____ DOB:_____/_____/_____

☐ Send via US Postal Mail ☐ Send via Fax to (847) 490-8999 ☐ Please Give to Patient

I hereby give my consent and authorize to the following facility:

Advance Midwest Medical, S.C.
Rajiv K. Sood, MD & Associates

1585 N. Barrington Road
Doctors Bldg. 2 – Suite 501
Hoffman Estates, IL 60169-5020
Tel: 847.490.8900 Fax: 847.490.8999

To have access to my;

Medical Records, Physician Notes, Laboratory Reports, Pathology Reports, Radiology Reports, Procedural/Operative Reports and Consultation Reports.

I understand that I may revoke this consent in writing at time, although not retroactively, and that upon fulfillment of the above request medical information or the lapse of 6 months from the date of signature, whichever comes first, this consent will automatically expire without my expressed revocation. A photocopy of this authorization shall be as valid as the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 C F R 165.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. The patient's medical record is privileged information, which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

I understand that the information in my health record may include information relating to sexually transmitted diseases, such as the Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient must sign unless he/she is a minor under 18 or is unable to sign. If signature is not of a patient, indicate the relationship to patient.

Patient Signature: _____ Date: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Parent ☐ Adult Child ☐ Sibling
☐ Legal Guardian ☐ Health Care Power of Attorney