

ANALYTE PHYSICIANS GROUP

REQUEST AND AUTHORIZATION TO COPY HEALTH INFORMATION

Patient Name				
Birthdate		Today's Date		
Address	City	State	Zip	Phone
e-mail address				
I authorize APG to use or disclose the following health information during the term of this Authorization. Check all that apply.		<input type="checkbox"/> Test results <input type="checkbox"/> Therapy notes <input type="checkbox"/> Complete medical record <input type="checkbox"/> Billing records		
For the following dates of treatment		<input type="checkbox"/> All dates <input type="checkbox"/> Specific date: _____		
Health Information Format		<input type="checkbox"/> Paper copy <input type="checkbox"/> Electronic copy		
Delivery Method		<input type="checkbox"/> In person review <input type="checkbox"/> US Mail <input type="checkbox"/> Electronic mail		
Send To – Name		e-mail		
Address	City	State	Zip	Phone
SPECIFIC CONSENT By checking any of these boxes, I am specifically authorizing APG to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.		<input type="checkbox"/> Information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered or performed, regardless of the result of the test) <input type="checkbox"/> Information about Communicable Diseases <input type="checkbox"/> Information about Venereal Diseases <input type="checkbox"/> Information about Substance (i.e. alcohol or drug) Abuse <input type="checkbox"/> Information about Sexual Assault <input type="checkbox"/> Psychotherapy notes which are not part of the official medical record		
This authorization will remain in effect until the purpose is fulfilled. I understand that I may revoke this Authorization in writing at any time by notifying the APG Chief Compliance Officer. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that APG has already taken action where it relied on my permission.				
Signature of Patient or Personal Representative			Date	
Name of Personal Representative			Relationship to Patient	
Please return this form to:		CHIEF COMPLIANCE OFFICER ANALYTE PHYSICIAN GROUP 328 S JEFFERSON ST STE 770 CHICAGO IL 60661		PHONE – 855-739-4325 FAX – 312-276-8522 E-MAIL – compliance@analytephysiciansgroup.com