



Name	Last	First	Middle	Maiden/Other	Date of Birth
Address	City	State	Zip Code	Telephone Number	

<p>I Authorize and Request:</p> <p>Name and Address</p> <p><u>Mercy Algonquin Medical Center</u> <u>2401 Harnish Drive Suite 101</u> <u>Algonquin, IL 60102</u> <u>Phone: (847) 458- 5440</u> <u>Fax: (847) 458-5450</u></p>	<p>To release to:</p> <p><input type="checkbox"/> Dr. Aijaz Alvi <input type="checkbox"/> Dr. Nishat Alvi</p> <p>Appointment Date: _____</p> <p>Specialty Care Institute 602 Fox Glen Court Barrington, IL 60010 Fax: (847) 277-0444 Phone: (847) 277-0111</p>
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<p>The Following information:</p> <p><input type="checkbox"/> All Ophthalmology Records on paper or EMR, Including but not limited to: Ophthalmology Progress Notes plus Snapshot</p> <p>OCT (Optical Coherence Tomography) in Color</p> <p>Ophthalmology Diagnostic Tests Fundus Photos in Color</p> <p>Contact Lens Records Visual Fields</p> <p>Ophthalmology Operative Notes Corneal Topography</p>	<p>The Following Information:</p> <p><input type="checkbox"/> All Otolaryngology Records on paper or EMR, Including but not limited to: ENT Progress Notes plus Snapshot</p> <p>Radiology Reports Laboratory Reports</p> <p>Pathology Reports ENT Procedures</p> <p>ENT Operative Notes</p>
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I understand that this information disclosed could contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) / HIV information. I understand that I have the right to inspect and/or obtain a copy, (for the appropriate fee) of the information prior to disclosure. I understand that if I do NOT disclose needed information it could affect my insurance companies' ability to pay for a claim associated with this visit and I may be responsible for any charges. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to the facility. This authorization will be considered valid for a 90 day period following the date of signature, unless otherwise specified here; _____. I absolve the individual or agency identified above together with its officers and employees from any legal liability which may arise from the disclosure of this information.

<p>_____</p> <p>Patient Signature</p> <p>_____</p> <p>Witness Signature</p>	<p>_____</p> <p>Date Signed</p> <p>_____</p> <p>Date Signed</p>
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Dear _____ ,

Enclosed you will find a Release Form to authorize the release of records. Please fill out the form and include the date of your next appointment.

Please mail or fax copy to; Mercy Algonquin Medical center
2401 Harnish Drive
Algonquin, IL 60102
Fax: (847) 458-5450

Thank You,

Dr Alvi and The Specialty Care Institute Staff