Northwest ENT Associates, S.C.

Victor P. Mokarry, M.D.
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Otolaryngology—Head and Neck Surgery

I hereby authorize Northwest ENT Associates S.C. ("NWENT") to release to:

First Name: _______________________________________Last Name: ____

Address: ____Fax or email____

Information contained in the patient record of: __________________________________, Date of Birth____________________

The following information may be released:

□ Entire Medical Record - Excluding the following: ____

□ Only these listed items: ____

By initialing any of the lines below, I am specifically authorizing NWENT to use and/or disclose the category of confidential Information indicated next to the line, if applicable to this authorization.

_________ Genetic Testing (ex: BRCA, PTEN, MSH2, etc)   ______ Alcoholism Treatment Records

_________ Drug Abuse Treatment Records   ______ Mental Health Treatment Records

_________ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

The above information for the following period of time shall be released:

From __________________ to ____________________

PURPOSE OF DISCLOSURE: ____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that NWENT may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to NWENT of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where NWENT has already relied on it to use or disclose my health information. Written revocation must be sent to NWENT at the following address: 800 Biesterfield Rd, Suite 401, Elk Grove Village IL 60007. Absent such written revocation, this Authorization for Release of Confidential Heath Information will terminate twelve months from the date below.

Signed: ____

Dated :_________________________

If you are not the patient, please state your authority to act on behalf of the patient:______________________________

Representative Name: ____

Representative Address: ____

Representative Phone / Email: ____

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