Lisa Sullivan, M.D.
Angela Oest, MPH, P.A.-C
Kathleen Finneke, P.A.-C

Specializing in Pediatric and Adult Allergy, Asthma, and Immunology

AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Patient Name: ____ DOB: ____________

SSN: ______________________________ Previous Name: ____________________________

I request and authorize ____ to release healthcare
(Name of Physician or Office that we will be receiving records from)
information of the patient named above to:

Dr. Lisa Sullivan or Associate

355 W. Dundee Rd #110
Buffalo Grove, IL 60089

175 E. Hawthorn Pkwy #220
Vernon Hills, IL 60061

Phone: (847) 541-4878 Fax: (847) 520-0500

This request and authorization applies to:

( ) Progress Notes
( ) Allergy Testing Results
( ) Spirometry Results
( ) Laboratory Results
( ) X-ray reports
( ) Immunotherapy Records
( ) Other ________________

This information will be disclosed for the following purposes: ___________________________

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I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practices Privacy Contract. I know that revoking this authorization would not prohibit any release of information by Dr. Lisa Sullivan in reliance on my original authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the regulations.

If this authorization was given as a condition of obtaining insurance coverage, the insurance company has the right to contest a claim made under the insurance policy.

Signature of Patient/Representative: ___________________________________ Date: ________

Relationship if not patient signature: Parent: ____, Legal guardian ____, other ______________

This authorization expires 90 days after date signed.