Abdallah Karam, M.D., S.C.
657 E Golf Road, Suite 306 Arlington Heights, Illinois 60005
Telephone: 847-427-2100 Fax: 847-427-2111

I, _____, authorize:

Facility/Doctor's Name _____.

Address:_____ Phone:_____

FAX:_____ to release the patient record of _____

date of birth_____.

to: Abdallah Karam, MD, SC
657 E. Golf Road, Suite 306
Arlington Heights, IL 60005

I authorize the release of: _____The entire medical record, excluding alcoholism treatment, drug abuse treatment, mental health treatment, and HIV/AIDS records. Please check off and INITIAL the items listed below that you wish to authorize additional disclosure of conditions:

_____ Alcoholism Treatment Record
_____ Drug Abuse Treatment Record
_____ Laboratory Reports
_____ Mental Health Treatment Records
_____ Operative/Pathology Records
_____ HIV/AIDS Records
_____ X-Ray, MRI, CT, PET Reports
_____ Other

The purpose of this authorization is _____.

I understand that:

- ♦Under this authorization I have a right to inspect and copy information that is being disclosed or used. I also understand that if I refuse to authorize the release of any information it will not be disclosed or used unless mandated by law.
- ♦Treatment will not be conditioned on whether I sign this authorization. The exception would be if condition of care were for creating personal health information for a third party.
- ♦Information that is disclosed or used with this authorization may be subject to redisclosure and therefore may no longer be protected by law.
- ♦I may revoke this authorization at any time by giving written notice to the above office address and Privacy Contact: Practice Manager of Dr. Abdallah Karam.

This authorization is valid from_____ until_____ at which time it will terminate.

Signature: _____ **Date**: _____

If you are not the patient, please specify your relationship to the patient._____

Revised 7.27.2017