Dr. Olena Gordon M.D
8937 W Golf Road Niles, IL

Consent for Release and Use of Confidential Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

I hereby authorize Dr. Olena Gordon to release any and all information concerning my illness and treatments to insurance companies, referring physicians, and/or other specified parties assign benefits to my physician that may otherwise be payable to me for services rendered to myself or my dependents. I understand that by signing this document, I am responsible balances due that not paid by my insurance. The cost of any record transfer will be **$25.00** for the first 15 pages. Any additional pages will be at **$0.55** per page.

I understand this consent is valid until revoked by me. I understand that I may revoke this consent any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Patient Name:_____ Date: _____.

Signature:_____ Date: _____.