Phone: (847) 639-5800 Fax: (815) 526-3467

AUTHORIZATION FOR RELEASE OF INFORMATION
MEDICAL RECORDS

☐ Complete Records ☐ History & Physical ☐ Progress Notes ☐ Care Plan

☐ Lab Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Treatment Record

☐ Operative Reports ☐ Medication Record ☐ Other:_____

Date(s) of Service from: _____ to _____

The Information is to be used/disclosed for the following purpose(s) only: _____
(no purpose is required if the patient is requesting and does not wish to disclose)

By signing this form, I Authorize _____

Phone: _____ Fax: _____
To release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/ person/ facility/ entity listed below

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending on /in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Patient Name (Printed) Patient Signature (Patient Representatives Signature)

_____ _____
Patient DOB Date