



Medical Records Release Form

Phone: (847) 519-4701 / Fax: (847) 519-4707

- Complete Records, Lab Reports, Operative Reports, History & Physical, Radiology Reports, Hospital Reports, Progress Notes, Pathology Reports, Medication Record, Care Plan, Treatment Record

Other: \_\_\_\_\_
Date(s) of Service: \_\_\_\_\_ to \_\_\_\_\_

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: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The purpose/reason for this release of information is as follows:

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 DOB or SS#

Date

Action Taken:

Mailed / Faxed / Picked Up on: \_\_\_\_\_ By: \_\_\_\_\_
(Circle One) (Date) (Staff Member)