Record Release Consent

Patient Name ____ Date of Birth________________________________

Street ____ S.S. # ______________________________________

City, State, Zip ____ Telephone No. _______________________________

I hereby authorize ____
(Name) (Address)
to release information as described below to:

Dr.____
680 N. Lake Shore Drive, Suite 118
Chicago, Illinois 60611
Phone: (312) 503-6000
Fax: (312) 503-6329

for the purposes of: ____

Type of Information to Be Released: *(check one)*

☐ Entire Medical Record

☐ Covering records *(date)*
from______________________
to________________________

☐ Other
____
____

In addition, I authorize that this will include health information relating to ***(check if applicable)***:

☐ HIV/AIDS Infection ☐ Drug/Alcohol Abuse ☐ Genetic Testing ☐ Psychiatric Treatment

Expiration:

This authorization will expire when acted upon or 6 months from this date ***(insert date)*** ___________________________.

I understand that:

1) I have the right to request a copy of this form after I sign it .
2) I may revoke this authorization at any time by notifying the authorized provider in writing.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

____
Signature of Witness

____
Date