Medical Records Release Form

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

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