

7055 High Grove Blvd. Ste. 100 Burr Ridge, IL 60527

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:			SS#
Address:			
Date of Birth: _	Phone:		
I authorize the rel	ease of the following me	edical in	formation to Pain Specialists of Greater Chicago:
	Physician Notes		Radiology Imaging Reports
	EKG/ EMG Reports		Admission/Discharge
	Surgical Reports		Patient Insurance Information
	Any & All		Other:
	Document Date: From		То
From:			
Phone:		F	ax:
Address			
		55 High Burr	ical Records Grove Blvd Ste. 100 Ridge, IL 60527 99 Fax 877-295-7647

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care solely for the purpose of creating protected health information for disclosure to a third party.

- I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by law.

- I understand that this authorization is valid until it expires, unless revoked before that.

- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on ______.

Pt. Signature

Date

If the patient is a minor, subject to guardianship. I have signed my name below on behalf of the patient and myself.