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 release of the following medical information 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 ________ to ________

From: ________________________________________

Phone: ____________________ Fax: ____________________

Address. ________________________________________

Please Fax to: Medical Records
7055 High Grove Blvd Ste.100
Burr Ridge, IL 60527
Phone 630-984-4799 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 Irefuse 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 tore-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 Imay revoke this authorization at any time by giving written notice to the physician of my desire to do so. Ialso 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.

______________________ ______________
Parent's, Legal Guardian's or Agents signature Date

rev9/17