



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 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.

Parent's, Legal Guardian's or Agents signature

Date

rev 9/17