Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

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*