Elmhurst: 1200 S. York Rd., Suite 4110, Elmhurst, IL 60126 p: 630-510-7666 f: 630-279-2519
Hinsdale: 550 W. Ogden Ave., Hinsdale, IL 60521 p: 630-323-6116 f: 630-323-6169
Joliet: 951 Essington Rd., Joliet, IL 60435 p: 815-744-4551 f: 815-744-4756
Naperville: 2940 Rollingridge Rd., Suite 102, Naperville, IL 60564 p: 630-579-6500 f: 630-579-5860
New Lenox: 1870 Silver Cross Blvd., Suite 200, New Lenox, IL 60451 p: 815-462-3474 f: 815-462-1032
Oak Park: 1 Erie Ct., Suite 7120, Oak Park, IL 60302 p: 708-848-4662 f: 708-848-4695
Western Springs: 4700 Gilbert Ave., Suite 50, Western Springs, IL 60558 p: 708-387-1737 f: 708-387-1720
Westmont: 1010 Executive Ct., Suite 250, Westmont, IL 60559 p: 630-920-2350 f: 630-323-5610

Authorization for Release of Information

Patient name: _____
Last First MI Maiden or other name

Date of birth: _____ SSN# _____ Medical Record # _____
Month Day Year

Address: _____ City: _____ State: _____ Zip: _____

Day phone: _____ Evening phone: _____

I herby authorize the above identified Provider to release information from my medical record as indicated below to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released below for dates:_____

- ☐ Completed health record
- ☐ History and physical exams
- ☐ Operative reports
- ☐ Progress notes
- ☐ Therapy notes
- ☐ Other_____
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ X-ray / MRI reports
- ☐ X-ray / MRI films
- ☐ Lab reports

I specifically authorize the release of any/all information in my record on:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health issues
- ☐ Communicable disease information (hepatitis, AIDS, HIV)

X_____
Signature of patient or legal guardian Date

Purpose of disclosure:

- ☐ Changing physicians
- ☐ School
- ☐ Consultation/second opinion
- ☐ Insurance (e.g., Life, Voluntary)
- ☐ Continuing care
- ☐ Workers' compensation
- ☐ Legal
- ☐ Other (please specifiy)_____

1. I understand that this authorization will expire on (date) or one year from the date of this signed form
2. I understand that I may revode this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent actional already has been taken in reliance upon it.
3. I understand that the information used or disclosed pursant to this authorization my be subject to redisclosure by the recipient and no longer be proted by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _____ (print provider name) for the purpose of: _____

   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that the above identified provider wil / will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I undersetand that in compliance with the State of Illinois statues, I will pay a fee of $_____ (print the fee charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up and the request is received directly from the facility.

_____ Date
Signature of patient

Or

_____ Date
Patient/Legal guardian/ Authorized person

_____ Date
Records received by

Or

_____ Date
Relationship to patient

For office use only

Date request complete:_____ **Employee name:**_____

Identification presented_____ **Fee collected $** _____ ☐ **Cash** ☐ **Check** ☐ **Charge**