Family Practice Specialist, S.C

Authorization for the Release of General Medical Record

This is to authorize that medical information regarding the following patient be forwarded:

Patient Name: _____ Date of Birth: _____

Address: _____City:_____ State: _____Zip: _____

FROM:

Family Practice Specialist, S.C
22285 Pepper Road
Lake Barrington, Il 60010
Phone: 847-277-9700 Fax: 847-277-9708

TO: Facility/institute: _____

Address: _____City:_____ State: _____Zip: _____

Telephone: _____ Fax: _____

Purpose of request: _____

Disclosure is limited to: **CIRCLE and Complete**

1. Records regarding admission and treatment for the following medical condition or injury

   _____

2. Records for the period (dates) from: _____to _____

3. The following specific information: _____

4. Send all records. No limitations placed on dates, history of illness, or diagnostic therapeutic information.

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the law. I also understand that I may revoke this consent at anytime except to the extent that the action has already been taken in reliance on it, and that in any event this consent expires automatically 90 days after signing.

Date: _____Signed: _____
Patient or Parent/Legal Guardian

Signed: _____
Witness

Date Received:____/____/____ Date Copied: ___/___/___ Copied By: _____MD approval_____

Revised: October 2015