

Suburban Neurologists, S.C.
800 Biesterfield Rd. #2009
Elk Grove, IL. 60007
Phone (847) 952-9140 Fax (847) 952-9145

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please print):

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

Physician: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Phone: _____

Fax: _____

TO

Physician: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Phone: _____

Fax: _____

Please release a copy of all my medical records, including, but not limited to progress notes, operative notes, laboratory results and diagnostic test.

The person or agency to which information is disclosed may not disclose this information to any other parties unless I specifically consent to such disclosure. I understand I have the right to inspect and copy the information disclosed. I understand I have the right to revoke this consent at any time. I understand that my refusal to consent to the release of information specified above will prevent disclosure of such information to those named herein.

Patient Signature: _____ **Date:** _____