KOMPREHENSIVE PRIMARY CARE AND SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name of Patient: _____ Medical Record Number: _____

Date of Birth: _____ Telephone Number: _____

IF YOU ARE NOT THE PATIENT:
Please print your name: _____

Please state your relationship to patient: _____
What gives you authority to receive the patient's information?

- ☐ Written patient authorization (please attach)
- ☐ You are the patient's parent or guardian (please attach evidence)
- ☐ You are the patient's health care decision maker (please attach evidence, such as a medical power of attorney)
- ☐ The patient is deceased and you are the personal representative of the patient's estate (please attach evidence)
- ☐ Other (please explain): _____

PLEASE RELEASE THE MEDICAL RECORDS FROM:

_____
(Physician or Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone/Fax Number)

INFORMATION REQUESTED: (Check all that apply)

- ☐ Medical/Legal
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Psychiatric Information
- ☐ Alcohol/Drug Information
- ☐ Abstract Lab Results
- ☐ Outpatient Report
- ☐ X-ray Report
- ☐ Emergency Room Report
- ☐ Other (Please specify)

The purpose of this release of information: _____
Dates of treatment: _____

I fully understand the following conditions:
1. My medical record and the information therein associated with the dates of treatment and/or hospitalization stated above may contain mental health, development disabilities, alcohol/substance, and/or AIDS/HIV test results.*
2. The medical record and/or medical information that are to be released herein are privileged and confidential and may be released only by proper authorization, except as required by law.
3. I have the right to a copy of my medical record and to inspect the information and to revoke this authorization at any time by submitting a written revocation to the Medical Record Department.
*Age 12-17: Patient and parent/legal guardian must sign and date (Psychiatric/Alcohol/Drug).

Komprehensive Primary Care & Sports Medicine S.C.
18350 S. Kedzie Suite 101
Homewood, IL 60430
Phone: (708)365-1055

Signature_____ Date_____

Parent/Legal Guardian Signature_____ Date_____