36 Main St., Suite 106, Park Ridge, IL 60068
Phone: 847-692-6692 Fax: 888-440-2577

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other _____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____/_____/2013

Parent/Guardian Signature: _____ Date Signed: _____/_____/2013

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.