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# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

| ___________________________ | ___________________________ |
|---|---|
| Name of Patient (Print) | Street Address |
| ___________________________ | ___________________________ |
| Phone Number | City State Zip |
| ___________________________ | ___________________________ |
| Date of Birth | Last Four Digits of SSN (optional) |

*I hereby authorize Illinois Cardiovascular Specialists to* **release/obtain [Please select one]** *my records to/from:*

*Please fill in the complete name and address of the medical facility or entity you would like your records **sent to or obtained from**. **[Please select one]**
Phone number:
Fax number:

___________________________
___________________________
___________________________

*The Protected Health Information I would like to have released is as follows (check one)*:

___ Release my entire chart (subject to state regulated per page fees)

___ I would like specific dates of service ______________________________

I am requesting my information to be disclosed for the following reason: ______________

I understand this authorization will expire 90 days from the date of signature.
I understand I may revoke this authorization in writing at any time.
I understand I am entitled to a copy of this authorization upon request.
I hereby acknowledge that the information I have given on this form with signature is true and correct.
I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

| ___________________________ | ______________ |
|---|---|
| Signature of Patient | Date |
| ___________________________ | ______________ |
| Signature of POA or other individual who has legal authority. | Date |

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