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ILLINOIS CARDIOVASCULAR SPECIALISTS

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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 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. _____

_____

_____

*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 _____