

**Photo ID** **of Parent, Legal Guardian or Patient (if over 18) is required to pick up Medical Records**

**Fax to 815-609-1328**

**SUBURBAN HEALTHCARE ASSOCIATES, Ltd.**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**From the office of: [Suburban Healthcare Associates] Authorize Release from:** **[ ]**

13415 S. Route 59 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plainfield, IL 60585 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE FOLLOWING PATIENT(S):**

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parent, Legal Guardian or Patient Signature\***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*If over 18, patient signature required.**

**PLEASE CHECK INFORMATION TO BE RELEASED:**

* \_\_\_\_ Immunizations Only
* \_\_\_\_ All Medical Records
* **I UNDERSTAND THAT THIS MAY INCLUDE THE FOLLOWING INFORMATION:**

**Check any areas that you do NOT want information released**

* \_\_\_\_ AIDS \_\_\_\_ HIV \_\_\_\_ Drug/Alcohol Abuse \_\_\_\_ ADHD

**PLEASE CHECK APPROPRIATE SPACE:**

* \_\_\_\_ I am remaining a patient, but am seeking care from a specialist physician.
* \_\_\_\_ I am moving out of this area.
* \_\_\_\_ I have a new insurance and must transfer care.
* \_\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**THIS AUTHORIZATION IS VALID FOR 60 DAYS FROM THE DATE SIGNED ABOVE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME.**

Date of Revocation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revoked by (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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THE FACILITY, ITS EMPLOYEES, OFFICERS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Office Use Only Below This Line\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

* Records Requistion **Faxed**  to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_