



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

Suburban Healthcare Associates

**Prepayment is required before chart is copied**  
Immunization information is available at no charge  
Please allow two weeks to copy records  
Fax to 815-609-1328

**SUBURBAN HEALTHCARE ASSOCIATES, Ltd.**  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**From the office of:** [Suburban Healthcare Associates]  
13415 S. Route 59  
Plainfield, IL 60585

**Authorize Release to:** [ ]  
\_\_\_\_\_  
\_\_\_\_\_

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

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

DOB: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent, Legal Guardian or Patient Signature\* Required at the time that records are picked up.**

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

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

**PLEASE CHECK INFORMATION TO BE RELEASED:**

- \_\_\_ Immunizations Only (no charge)
- \_\_\_ All Medical Records (\$.97 for pgs 1-25) + (\$.65 for pgs 26-30) + (\$.32 for pgs 51 and up)  
\_\_\_\_\_ phone number where you can be reached for total.

**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**\*\*\*\*\*

- Amount Paid: \_\_\_\_\_ Date Paid: \_\_\_\_\_ Paid by: \_\_\_ CK \_\_\_ CH \_\_\_ CA
- Records **Mailed** to: (name) \_\_\_\_\_ Date: \_\_\_\_\_  
(address) \_\_\_\_\_ Initials: \_\_\_\_\_
- Records **Picked up** by: (signature) \_\_\_\_\_ Date: \_\_\_\_\_  
Photo ID copied: Initials: \_\_\_\_\_
- Records **Faxed** to: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_  
Fax number: \_\_\_\_\_