Suburban Healthcare Associates

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]
13415 S. Route 59
Plainfield, IL 60585

Authorize Release from: [ ]

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE FOLLOWING PATIENT(S):
Name(s): _____ DOB: _____
_____ _____
_____ _____

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: _____