Osteopathic Healing Arts, LLC
1029 W. Park Avenue
Libertyville, IL 60048-2550
Email: ohadpc@gmail.com
Fax: 847-362-6668

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone No: _____ Email: _____

I authorize release of my medical records: [CHECK ONE ONLY]

☐ To: Osteopathic Healing Arts, LLC at the above address

From:

_____
Name address Fax

OR

☐ To the following doctor/clinic: _____
Name

_____
address Secure fax number

Please indicate all item(s) that apply:

__Clinic Records	__Consultations	__Discharge Summary
__Lab Reports	__History & Physical	__E/R Reports
__Operative/Pathology	__HIV antibody Reports	__Imaging Reports
__Psychiatric	__Drug/Alcohol Abuse	__Entire Record

__Other _____

Approximate dates of treatment: _____

Purpose of health information to be released: _____

Please release my records by (circle): email fax paper copy pick-up

*I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. I understand that this consent is valid for 90 days from the signature date. I can revoke this authorization at anytime by giving written notice to Osteopathic Healing Arts, LLC. I agree to pay **$20 per** patient records request.*

_____ _____
Signature of patient or authorized legal guardian Date

_____ _____
Relationship to patient, if signed by legal representative Witness