

**Osteopathic Healing Arts, LLC**

1029 W. Park Avenue  
Libertyville, IL 60048-2550  
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**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:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Clinic Records      | <input type="checkbox"/> Consultations        | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Lab Reports         | <input type="checkbox"/> History & Physical   | <input type="checkbox"/> E/R Reports       |
| <input type="checkbox"/> Operative/Pathology | <input type="checkbox"/> HIV antibody Reports | <input type="checkbox"/> Imaging Reports   |
| <input type="checkbox"/> Psychiatric         | <input type="checkbox"/> Drug/Alcohol Abuse   | <input type="checkbox"/> Entire Record     |
| <input type="checkbox"/> 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