9201 Waukegan Rd
Morton Grove, IL 60053
P: 847-759-4770
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INCOMING MEDICAL RECORDS RELEASE REQUEST

I hereby authorize _____, to release the Medical Records of:

Please Print
Name: _____

Date of Birth: _____

The following information is to be released:

____Laboratory Tests	____Progress Reports	____All Records
____Radiology Reports	____Medication Records	____Other
____Pathology Reports	____All Records	

Please state specific information and include dates of treatment:

_____

_____

Please forward Medical Records to:

North Suburban Pulmonary & Critical Care Consultants
9201 Waukegan Rd
Morton Grove, IL 60053

Reason for Release:

____Moved	____Change Physician	____Insurance Change

Other (please specify) _____

Limits/exclusions: I do ___ I do not ___specifically consent to transmit of my medical record via fax.

Signature of patient: _____ Date: _____

I recognize that the information disclosed may contain Mental Health, Drug/Alcohol, and HIV/AIDS testing that is protected by Federal/State law. I specifically consent ___ do not consent___ to disclose of such information.

Signature of Patient: _____ Date: _____