# AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

**PATIENT INFORMATION**

Patient Name: _____ Date: _____

Phone:_____ Date of Birth: _____

Address: _____ City/State/Zip: _____

**RELEASE FROM**

I authorize release of my medical record from:

Physician/Facility Name: _____

Facility Address: _____

Facility Phone: _____Facility Fax: _____

**RELEASE TO**

This information may be disclosed and used by the following individual or organization:
**Facility : Dr. Sayyed - Family Doctor**
**Address: 7650 S. County Line Rd IL, 60527**
**Phone : 630-822-2242**
**Fax : 630-568-5671**

**RELEASE INFORMATION**

**Reason:** Continuation of Care

**Specific Information Requested:**

**Date Range:** From_____ to _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I can refuse to sign this authorization. I need to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

**Signature of Patient / Parent / Guardian or Authorized Representative**

**Signature:**_____**Date:**_____