AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION
Chicago Institute For Neuropathic Pain
Phone: 312-809-6500 Fax: 312-809-6501

PATIENT INFORMATION (Please print)

Patient Name | Date of Birth

Address | City | State | Zip | Phone

RELEASE FROM (Name of physician releasing information)

I authorize release of my medical record from:

Physician/Facility

Address | City | State | Zip | Phone | Fax

RELEASE TO: (Name of physician or facility receiving information)

Please send my medical record to:

Chicago Institute For Neuropathic Pain/ Dr. Michael Rock

Physician/Facility

7101 W Higgins Ave | Chicago | IL | 60656 | 312-809-6500 | 312-809-6501

Address | City | State | Zip | Phone | Fax

RELEASE INFORMATION

Reason: ( ) Change of Insurance ( ) Transfer of Care ( ) Personal File
( ) Moving out of Area ( ) Specialist Consultation ( ) Other

Please release the following (check all that apply)

The information for the following time period shall be released: From:_____ To:_____

____The entire medical record excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/AIDS records

To be disclosed, the following items must specifically be checked:

___Mental Health Treatment Records ___Drug Abuse Treatment Records
___Alcoholism Treatment Records ___HIV/AIDS Treatment Records

_____Lab Reports
_____Xray Reports
_____Hospital Reports
_____Other _____

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization.

Signature of patient, guardian, conservator or patient representative (please circle if not patient) Date

This consent is valid for 90 days. It may be revoked by the signer at any time.
*Please allow 15 days for processing
*Use of this information for any other than the stated purpose is prohibited
*Incomplete information will delay processing
*This information is for the use of the designated recipient only and cannot be provided to any other agency