Commonwealth
Medical Physician Group

2800 North Sheridan Road
Suite 400
Chicago, Illinois 60657-6157
www.commonwealthmedical.com
773/472-5803

RELEASE OF MEDICAL RECORDS
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION ON:

PATIENT'S NAME: _____
(First) (Middle initial) (Last)
DATE OF BIRTH: _____

Previous Name(s):_____

I hereby authorize the physician/or physician group of: _____
_____
at street address, city, state, zip: _____
_____
_____
to release my medical records to:

COMMONWEALTH MEDICAL
2800 N. SHERIDAN RD., #400
CHICAGO, IL 60657-6157
773/472-5803

This request and authorization applies to:

_____ Health care information relating to the following treatment or condition*/
or the following dates of service:_____
_____

_____All Medical Records*

*I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, Psychiatric disorders/mental health or drug and/or alcohol use, you are specifically AUTHORIZED to release all health care information relating to such diagnoses, testing or treatment.

_____
Signature of named Patient or Authorized Representative Date Signed

Printed Name:_____
(First) (Last)
Relationship and status of Authorized Representative's signature: (Legal Guardian, Power of Attorney or Executor of Estate):

_____

THIS AUTHORIZATION EXPIRES 60 DAYS AFTER SIGNATURE DATE
(Photocopy or Facsimile Signature will not be accepted)