

# ADVANCED CARE & TREATMENT MEDICAL GROUP, S.C.

2473 McFarland Road, Rockford, IL 61107 ♦ (815) 986-2286 ♦ Fax: (815) 986-2287

## MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Name: \_\_\_\_\_ Maiden/Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

My permission is hereby granted for the release of my medical information to the organization listed below. I specifically consent to the transmission of my medical information via a confidential facsimile machine if needed. I recognize that information disclosed may contain drug/alcohol, HIV/Aids testing, and/or mental health information.

I specifically consent to disclosure of such information. \_\_\_\_\_  
(patient initials)

I do not consent to the disclosure of such information. \_\_\_\_\_  
(patient initials)

The following information may be released:

_____ Complete record, last 5 year	_____ Doctors progress reports
_____ Laboratory data	_____ Radiology reports from _____
_____ Pathology reports	_____ History and physical reports
_____ X-ray films	_____ Other

Advanced Care & Treatment Medical Group, S.C. does not copy records from other facilities, attorneys, or insurance companies. If you have not picked up your records one month from the date your request is processed they will be destroyed.

Request Records from:

\_\_\_\_\_  
Name of Org., individual, agency, or facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

Furnish to:

\_\_\_\_\_  
Name of Org., individual, agency, or facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

I authorize release of my medical records as described above. I understand written notification is necessary to cancel this request. **This authorization is valid for six months after signing.**

\_\_\_\_\_  
Signature of patient/or legal guardian, POA

\_\_\_\_\_  
Date