Authorization for Release of Information

Date: _____

To:_____ Phone: _____
_____ Fax:_____

I authorize the release of my records indicated below from/to:

Group Business Title
Balance Health + Wellness
1901 North Clybourn, Suite 301
Chicago, IL 60614
773-472-0560 phone
773-472-0429 fax

- All Medical Records
- X-Rays
- All Imaging Reports
- Blood Analysis
- Other: _____

Reason for Request: _____

Dates of Care: from_____ to _____

Patient Name (please print):_____

Patient Date of Birth: _____

Home Address: _____

City/State/Zip: _____

Daytime Phone: _____ Fax: _____

This Authorization expires one year from date of signature. I may revoke this Authorization at any time. I am entitled to a copy of this Authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment for my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or if it is specifically required or permitted by law. I am entitled to notice if my information is used for marketing or results in remuneration to the provider. I hereby acknowledge that I have read understand the above statements as they apply to me.

Patient Signature: _____Date:_____

This authorization expired one year from the signature.

Fax Sent: _____ Date: _____ By: _____

Records Received: _____ Date: _____