

REQUEST/AUTHORIZATION TO RELEASE MEDICAL RECORDS

PLEASE PRINT

TO: _____
(Name of Facility, Physician/Provider or Agency)

(Street Address)

(City) (State) (Zip)

RE: _____ **DOB** _____
(Name of Patient: Last, First, Middle)

(Street Address)

(City) (State) (Zip)

I hereby request and authorize the above-named facility, physician/provider, and/or agency, for the purpose of coordinating care, to release all medical records including examination and lab results, imaging studies, and reports concerning the above-named patient to:

Drew Deppen, DC
800 Austin, West Tower
Suite 308
Evanston, IL 60202
Phone: 224-622-8766
Fax: 847-733-1528

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire three (3) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent.

(Patient's signature or Guardian's signature if patient is a minor)

(Date)