CHICAGO DIZZINESS AND HEARING

645 N. Michigan Ave., Suite 410
Chicago, Illinois 60611

Phone: 312/274-0197
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INFORMED CONSENT FOR RELEASE OF MEDICAL INFORMATION

Records to be released FROM: _____
(Name)
_____
(Address)
_____
_____

Records to be released TO: _____
(Name)
_____
(Address)
_____
_____

for the purpose of _____

The specific medical record information requested is _____

_____

as recorded in the medical record of my treatment from _____ to _____

Your obligation of confidentiality and that of your staff is waived as to the information described and the recipient(s) designated. You are released from all legal liability that may arise from the requested release of this medical record information. This authority extends to the furnishing of copies of all or any desired parts of the hospital records.

_____ Patient Name

_____ Patient Signature

_____ Social Security Number

_____ Date on which consent is signed

_____ Parent's or Guardian's signature if patient is a minor

_____ Date on which this consent will expire (where applicable)

This consent is subject to revocation at any time except to the extent that action has been taken in accordance with its terms.