

****Payment Required Prior To Copying****

Consent for Release of Medical Records

From: The Medical Care Group, LTD
1786 Moon Lake Blvd. Suite 216
Hoffman Estates, IL 60169
(847) 884-7550 Phone
(847) 884-7510 Fax

TO: _____

I authorize the release of medical records for the following:

Patient's Name: _____

D.O.B: _____

Home Number: _____

Alternative Number: _____

Copy:

_____ Entire **MEDICAL CARE GROUP** Medical Record

_____ Portion of medical record as indicated: _____

Reason for leaving the Practice:

_____ Moving _____ Change in Insurance

_____ Other, Please Explain _____

I hereby release The Medical Care Group, LTD from all legal responsibility or liability that may arise from the act I have authorized above.

Date: _____ Signature of Patient/Guardian: _____

Date: _____ Signature of Witness: _____