Midwest Sports Medicine
& Orthopaedic Surgical Specialists, Ltd.

☐ Midwest Sports Medicine
901 W. Biesterfield Road
Suite 300
Elk Grove Village, IL 60007
Phone: 847-437-9889
Fax: 847-437-4149

☐ Midwest Center for Pain Mgmt.
901 W. Biesterfield Road
Suite 101
Elk Grove Village, IL 60007
Phone: 847-437-9855
Fax: 847-437-9086

☐ The Center for Physical Therapy
975 E. Nerge Road
Suite N-140
Roselle, IL 60172
Phone: 847-437-9889
Fax: 847-944-1240

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST M.I. MAIDEN OR OTHER NAME

DATE OF BIRTH : ____ – ____ – ____ SS#: ____ – ____ – ____ MEDICAL RECORD #: _____
MO. DAY YR.

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I hereby authorize Midwest Sports Medicine & Orthopaedic Surgical Specialists Ltd. and its affiliates to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: ( ) _____ FAX: ( ) _____

INFORMATION TO BE RELEASED BELOW FOR DATES: _____

PLEASE MARK **ALL** THAT APPLY:

☐ Complete Health Record	☐ Therapy Notes	☐ X-ray / MRI Films
☐ History and Physical Exams	☐ Consultation Reports	☐ Lab Reports
☐ Operative reports	☐ Discharge Summary	☐ EKG Reports
☐ Progress Notes	☐ X-ray / MRI Reports	

☐ Other: _____

PURPOSE OF DISCLOSURE: ☐ Workers Compensation ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance (e.g., Life, Voluntary) ☐ Changing physicians
☐ Other (please specify): _____

1. I understand that this authorization will expire on (Date) _____ or 90 days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that in compliance with the State of Illinois statutes, I will pay a fee of $_____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up and the request is received directly from the facility.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY

DATE REQUEST COMPLETED: _____ EMPLOYEE NAME: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____
TYPE