Pfeiffer Medical Center / HRI
3S721 West Avenue, Ste 300
Warrenville, IL 60555
(630) 505-2842
Fax (630) 836-7056

Authorization for Release of Information/Medical Record

_____ _____
Patient Name Date of Birth

I, the undersigned, authorize the Pfeiffer Medical Center to disclose the following medical records:

_____ All Records ($75 fee) ____ Most Recent Lab Results Only ($10 fee)
_____ Result Packet ($15 fee)

Name of Physician or Medical Practice/Agency receiving records_____
_____
Address of Physician or Medical Practice/Agency receiving records _____
_____
Telephone _____Fax number _____
Reason for release: _____

There is a fee (see above) for obtaining a copy of the patient's medical records. Medical records will be sent upon receipt of payment. The Pfeiffer Medical Center accepts Mastercard, Visa, cashier's check or personal check. All medical records will be sent upon payment.
_____ I have enclosed a check.
_____ Please bill my credit card _____
(card number, expiration date and security code)
NOTE: Pertinent labs as medical records (not the entire chart) may be faxed to a physician for urgent care purposes only.

If not previously revoked, this authorization will expire one year from the date of my signature or as otherwise specified by date, event or condition(s) as follows:_____
_____

_____ _____
Signature of Parent/Guardian Date
_____ _____
Signature of Patient Date
_____ _____
Witness Signature Date

If this request is by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____
Personal Representative's Signature: ___ _____
Relationship to Patient: _____