CHICAGO LAKESHORE HOSPITAL
Authorization For EXTERNAL Release of Information

I, _____ hereby authorize_____
(Patient or legally authorized person) facility/physician/group

ADDRESS:_____CITY, STATE, ZIP:_____

To release the following information regarding:

Patient Name: DOB:

Address: City, State Zip

Please check all information to be released:

Entire Record Set	_____	PSYCHIATRIC EXAM.	_____	SCHOOL RECORDS	_____
MED. HISTORY & PHYSICAL EXAM	_____	TREATMENT PLAN	_____	SOCIAL HISTORY	_____
		PSYCHOLOGICAL EVAL	_____	OTHER (Specify)	_____
X-RAY REPORT	_____	DISCHARGE SUMMARY	_____	_____	

I authorize information to be released from the following time periods: _____ to _____.

I give my consent freely and voluntarily. I realize that treatment services will not be withheld if I do not consent to the release of this information.

Information shall be released to:

Medical Records Department
Chicago Lakeshore Hospital
4840 North Marine Drive
Chicago, Illinois 60640

(773) 878-9700 **(773) 907-4630 Fax**

1) I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or HIV or AIDS status, if applicable. It may also include information about behavioral or mental health status.
2) I understand that I may revoke this authorization at any time in writing; otherwise this consent will be considered valid for sixty (60) days.

_____ _____
Signature of patient if at least 12 years old Date

_____ _____
Signature of parent/guardian if patient Is under 18 years of age Relationship Date

_____ _____
Signature of Witness Date

Created on 6/27/2008