

**Cardiac EP Consultants**  
*Request for Release of Information*

I, \_\_\_\_\_  
Patient Name Date of Birth

HEREBY AUTHORIZE: CARDIAC EP CONSULTANTS  
900 TECHNOLOGY WAY, SUITE 220  
LIBERTYVILLE, IL 60048  
Phone: 847/367-7171  
Fax: 847/367-7177

TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING:

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE: \_\_\_\_\_  
FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_

FOR THE PURPOSE OF:  Continuing Care  Personal  Insurance Claims  
 Legal Proceedings  Other: \_\_\_\_\_

The specific information to be released is:

All pertinent documents on or near (specify date) \_\_\_\_\_  
 All pertinent documents related to (specify illness or injury type) \_\_\_\_\_  
 List any specific documents/dates \_\_\_\_\_

I understand that the information may include reference to, or treatment of, emotional illness, developmental disability, drug or alcohol abuse, and/or Human Immunodeficiency Virus (HIV) testing. I further understand that I may revoke, in writing, this authorization, except to the extent that it has already been acted upon. This authorization will expire 90 days from the date signed.

_____ Patient or Legal Representative (please print)	_____ Relationship (if other than patient)
_____ Patient or Legal Representative Signature	_____ Reason that patient cannot sign (if applicable)
_____ Date Signed	_____ Witness Signature (if needed)