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)**