Records Release Request

Date _____

Patient _____

Date of Birth _____

I hereby authorize _____ to release the following information during the periods from _____ to _____:

- ☐ *All medical records*
- ☐ Doctor's visit notes only
- ☐ Vaccination records
- ☐ All bloodwork results
- ☐ All Radiology reports
- ☐ STD screening results

- ☐ Only the following lab results/records:
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____

The above mentioned records are to be given to _____.

I understand that this authorization will expire one year from the signature date. However, I may revoke this authorization in writing at any time, except to the extent that the medical facility has relied upon it. I understand that the medical facility will not refuse to treat me based upon whether I agree to the release of my medical records.

Signature: _____

Witness: _____

If you have any questions, please contact:

Michigan Avenue Immediate Care
Michigan Avenue Primary Care
180 North Michigan Avenue, Suite 1605
Chicago, IL 60601
312-201-1234 MAIC Phone
312-994-3000 MAPC Phone
312-201-1202 Fax