PARK RIDGE
MultiMed

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name: _____ Date of Birth: _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (Home): _____ (Cell): _____

RELEASE MY RECORDS FROM:

Doctor/Office Name: _____

Phone #: _____

Fax #: _____

TO:

PARK RIDGE MULTIMED
Keith Berndtson, MD
15 N Prospect Ave
Park Ridge, IL 60068
PH 847.232.9800 FAX 847.232.9810

Records Requested: _____

_____

_____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at PRMM except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked **but will expire in one year after signing**. I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Patient: _____ Date: _____
Or Legal Guardian signature