



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