

STEPHEN J. CLARK M.D.,P.C.
CHRISTINE F. KHARASCH MD.
Family Practice

3021 FALLING WATERS BLVD. S-A
LINDENHURST, IL. 60046
PHONE 847-356-9300 FAX 847-356-7260 EMAIL sclark-md@lfp3021.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ or _____
Patient Name (please print) Authorized person (please print)

address: _____ phone: _____

hereby authorize: STEPHEN J. CLARK, M.D.,P.C.
3021 FALLING WATERS BLVD. S-A
LINDENHURST, IL. 60046

to release to: _____

The following medical records relating to (check all that apply):

Medical/Surgical Condition Psychiatric Illness All Medical Records
 Alcohol/Drug Abuse Lab/X-ray Other _____
(please specify)

from the medical record of _____
Patient Name (please print) Date of Birth

The above information is being released for the purpose of: (please specify: continuing medical treatment, reimbursement purposes, legal purposes, worker's compensation claim, etc..)

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician.

If not revoked, this authorization will expire on _____ (please specify) or ninety days after the date below, or sooner at my election.

I hereby release **Stephen J. Clark, M.D.** from any & all legal responsibility or liability that may arise from the disclosure or release of the information described above, including all liability for an alleged violation of having this information maintained in confidence & privacy.

I understand that fees will apply for copying of medical records as follows: Handling fee \$26.77 in addition per page 0-25 \$1.00 per page, 26-50 pgs. \$.67 per page, excess 50 pgs. \$.33 per page, & shipping.

Date

Signature

Relationship to Patient

Witness