STEPHEN J. CLARK M.D.,P.C.
Family Practice

3021 FALLING WATERS BLVD. S-A
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

address: ________________________________ phone: ________________

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

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..)

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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.

____________ ________________________________
Date Signature

________________ ________________________________
Relationship to Patient Witness