

*Pfeiffer Treatment Center
4575 Weaver Parkway
Warrenville, IL 60555
(630) 505-0300
Fax (630) 836-0667*

Authorization for Release of Information/Medical Record

Patient Name

Date of Birth

I, the undersigned, authorize the Pfeiffer Treatment Center to disclose the following medical records:

_____ All Records (\$30 fee)

_____ Most Recent Lab Results Only (\$10 fee)

_____ Result Packet (\$15 fee)

Name of Physician or Medical Practice/Agency receiving records _____

Address of Physician or Medical Practice/Agency receiving records _____

Telephone _____ Fax number _____

Reason for release: _____

There is a fee (see above) for obtaining a copy of the patient's medical records, unless the copy is sent to a physician's office or medical facility. Medical records will be sent upon receipt of payment. The Pfeiffer Treatment Center accepts Mastercard, Visa, cashier's check or personal check. All medical records will be sent upon payment.

_____ I have enclosed a check.

_____ Please bill my credit card _____

(card number, expiration date and security code)

NOTE: Pertinent labs as medical records (not the entire chart) may be faxed to a physician for urgent care purposes only.

If not previously revoked, this authorization will expire one year from the date of my signature or as otherwise specified by date, event or condition(s) as follows: _____

Signature of Parent/Guardian

Date

Signature of Patient

Date

Witness Signature

Date

If this request is by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____