



Patient ID: _____

Heal n Cure, SC
www.healncure.com

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date _____

Address _____

Soc. Sec. # _____ - _____ - _____ DOB _____

Receive Records From: _____ Release Records To:

Heal n Cure SC
Tel/Fax 847-686-4444

Please send a copy of my records as indicated for dates _____ of treatment:

Operative Records Lab Reports EGD/Colonoscopy Radiology Reports Angiography Discharge Sum
Consult Office Notes ECHO Stress test Sleep Study Other

Purpose for releasing medical information: Continuity of Care

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to AIDS related diagnoses, sexually transmitted diseases, psychiatric disorders and other mental health related issues.

Signature of Patient, Parent or Guardian _____ **Date**

Signature of Witness _____ **Date**

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