Medical Release Form

Please Fax this form to 708.876.0383

Patient Name ____ Date of Birth_____________________

Address____ City____________________________

State __________________ Zip Code ________________ Phone _______________________________

INFORMATION REQUESTED FROM

Name ____

Address _______________________________________ City___________________ State _______

Zip Code _____________

Phone Number ______________________________ Fax __________________________________

INFORMATION REQUESTED TO

Name: ____

Address_______________________________________ City___________________ State________

Zip Code _____________

Phone Number ______________________________ Fax__________________________________

**Records for the period (dates) from: ____________________ through _____________________

I ____ **(Name)** hereby grant permission to release my confidential health information from/to the above-named facility/physician/entity. This authorization will remain valid until revoked and **<u>will expire one year after signing</u>**. If you request medical records from Ticho Eye Associates, we are required by law to complete the request within thirty (30) days. In case your records are being transferred to another facility/physician, there will be no charge. However, if as a patient, you request copies of records to be dispensed to yourself, a fee will be charged based on the current Illinois state statute.

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Printed Name

____ _______________________________

Signature Date