

Center for Health and Healing, S.C.

Fred James Schultz, M.D. • Family Practice
2150 Manchester Road, Wheaton, IL 60187
Phone: 630-933-9722 • Fax: 630-933-9724

Authorization for Release of Medical Information (Please complete in full.)

1. Patient:

Name: _____ Date of Birth _____
Last First MI

Street Address

City State Zip Phone _____

2. Authorize records release FROM:

(Note: the processing fee is \$25)

Fred James Schultz, M.D.
2150 Manchester Road
Wheaton, IL 60187

3. Records released to:

Name: _____

Street Address

City State Zip Phone _____

4. Type or extent of information to be released: (please check all applicable categories).

- | | |
|--|---|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records Including Reports |
| <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Alcohol, Drug Abuse Reports |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Copies of All Other Reports/Correspondence |

5. Purpose or need for release: _____

6. This authorization will remain in effect for one year from the date the authorization was signed.

7. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

Patient signature _____ Date: _____

(If signed by person other than patient, state relationship to patient)

Patient is: Minor Incompetent Deceased

Legal Authority: Parent or Legal Guardian Next of Kin of Deceased