PERSONAL AND CONFIDENTIAL

REQUEST/AUTHORIZATION TO RELEASE MEDICAL RECORDS

PLEASE PRINT

TO: _____
(Name of Facility, Physician/Provider or Agency)

_____
(Street Address)

_____
(City) **(State)** **(Zip)**

RE: _____**DOB**_____
(Name of Patient: Last, First, Middle)

_____
(Street Address)

_____
(City) **(State)** **(Zip)**

I hereby request and authorize the above-named facility, physician/provider, and/or agency, for the purpose of coordinating care, to release all medical records including examination and lab results, imaging studies, and reports concerning the above-named patient to:

Evan Osar, DC
1030 W. North Ave #300
Chicago, IL 60642
Phone: 773-343-4012
Fax: 312-212-5569

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I have read and understand the above information and give my consent.

_____ _____
(Patient's signature or Guardian's signature if patient is a minor) (Date)

Revised 10/30/07