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Chicago, IL 60611
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Authorization Form
for
Release of Medical Records from CLSMA

PATIENT INFORMATION

Patient's Full Name

Patient's Social Security Number

Address

Patient's Date of Birth

City, State, Zipcode

Patient's Telephone Number

AUTHORIZATION

I hereby authorize Dr. _____ (CLSMA) to disclose protected health information about me for the purpose of:

- Patient Request Continuity of Care Insurance Attorney/Client Relationship

To the following (physician/hospital/person/class of persons):

NAME/INSTITUTION _____

ADDRESS _____

CITY, STATE, ZIPCODE _____

INFORMATION TO BE DISCLOSED

The following specific information should be disclosed: (please check all that apply and provide dates of service, if possible)

Progress Notes from _____ to _____

Radiology Results from _____ to _____

Lab Work from _____ to _____

EKGs/Echos/Cardiac Caths from _____ to _____

Other (please specify) _____

