

**Chicago Lake Shore Medical Associates, Ltd.**  
**676 North St. Clair Suites 2300 & 2000**  
**Chicago, IL 60611**  
**Telephone: (312) 926-6000 Fax: (312) 926-5971 (Suite A)**

**Authorization Form**  
**for**  
**Release of Medical Records to CLSMA**

**PATIENT INFORMATION**

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\_\_\_\_\_  
Patient's Full Name

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
City, State, Zipcode

\_\_\_\_\_  
Patient's Telephone Number

**AUTHORIZATION**

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I hereby authorize the disclosure of my protected health information for the purpose of:

- Patient Request     Continuity of Care     Insurance     Attorney/Client Relationship

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

NAME/INSTITUTION \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIPCODE \_\_\_\_\_

TO BE RELEASED TO:

Dr. \_\_\_\_\_ at

Chicago Lake Shore Medical Associates  
676 North St. Clair Suite 2300 or 2000  
Chicago, IL 60611

**INFORMATION TO BE DISCLOSED**

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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 \_\_\_\_\_

