MEDICAL RECORDS RELEASE AUTHORIZATION

I, ______________________________________, authorize and request release of medical records:

FROM:

Physician or Agency:____

Address:____

City, State, Zip: ____

TO:

_____ **Gateway Spine and Pain Physicians**

215 Remington Blvd, Suite G	**Office: 630-226-1130**
Bolingbrook, IL 60440	**Fax: 630-226-1134**

_____ Other:

Physician or Agency:____

Address:____

City, State, Zip:____

PLEASE CHECK ONLY ONE:

_____ I **DO** give permission to release information regarding the diagnosis of treatment HIV/AIDS or other sexually transmitted diseases, drug and /or alcohol abuse, mental illness or psychiatric treatment.

_____ I **DO NOT** give permission to release information regarding the diagnosis of treatment HIV/AIDS or other sexually transmitted diseases, drug and /or alcohol abuse, mental illness or psychiatric treatment.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time by my written statement. A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.

SSN:____ DOB:_________________________

Signature:____ Date:__________________________

Witness Signature:____________________________________ Date:__________________________