**STEPHEN J. CLARK M.D.,P.C.**

***Family Practice***

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# ***AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION***

I,_____ or _____
Patient Name (please print) Authorized person (please print)

address: _____ phone: _____

hereby authorize: STEPHEN J. CLARK, M.D.,P.C.
3021 FALLING WATERS BLVD. S-A
LINDENHURST, IL. 60046

to release to: _____
_____
_____

The following medical records relating to (check all that apply):
__Medical/Surgical Condition __Psychiatric Illness __ All Medical Records
__Alcohol/Drug Abuse __Lab/X-ray __Other_____
(please specify)

from the medical record of _____ _____
Patient Name (please print) Date of Birth

The above information is being released for the purpose of: (please specify: continuing medical treatment, reimbursement purposes, legal purposes, worker's compensation claim, etc..)

_____

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that refusal of my consent would prevent disclosure to my insurance company (if applicable) of information necessary to consider my claim. I understand that I have the right to revoke this authorization at any time by writing to my physician.

If not revoked, this authorization will expire on _____(please specify)or ninety days after the date below, or sooner at my election.

I hereby release **Stephen J. Clark, M.D.** from any & all legal responsibility or liability that may arise from the disclosure or release of the information described above, including all liability for an alleged violation of having this information maintained in confidence & privacy.

***I understand that fees will apply (based on state of IL) for copying of medical records as follows: Handling fee $33.60 in addition, 0-25 pgs. $1.26 per page, 26-50 pgs. $.84 per page, excess 50 pgs. $.42 per page, & shipping.***

_____ _____
Date Signature

_____ _____
Relationship to Patient Witness