Dr. Alan F. Bain DO
P: (312) 236 - 7010
F: (312) 236 - 7190

BAIN MED
DR. ALAN BAIN, DO

Medical Release of Information

Patient First Name | Patient Last Name | DOB

SEND INFORMATION TO:

Name of Recipient | Recipient Email | Recipient Phone | Recipient Fax

Recipient Address | City | State | Zip

INFORMATION TO BE DISCLOSED:

I authorize the release of the following health information:

_____ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the records indicated:

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312-236-7010
F: 312-236-7190

patientservices@docintheloop.com
www.docintheloop.com

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BAIN MED
DR. ALAN BAIN, DO

PURPOSE:

I authorize the release of my health information for the following specific purpose:

_____ At the request of the Patient _____Other purpose

AUTHORIZATION:

I authorize Dr. Alan F. Bain, DO or his staff to release confidential health information about me. You may release a copy of my medical records, or a summary or narrative of my protected health information to the recipient I have addressed above. I understand that this authorization will remain in effect until the provider fulfills this request.

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

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