Sholtes and Associates, LTD Robert M. Sholtes, M.D. Susan K. Sholtes, L.C.S.W.

## **Release of Information**

Telephone: (847)328-1920 Fax No.: (847)328-1925

Requesting info	rmation regarding:	1 1		
Name of Client		Date of Birth	SSN	, Daytime Phone
The client or gu	ardian hereby auth	orizes and requ	uests:	
		to furnis	sh To/From:	
Name of person or in	stitution			ert M Sholtes, M.D.
Address		<del> </del>	– 500 Davis St Suite 1006	
City, State Zip			Eva	nston, IL., 60201
Telephone	Fax Number	<del> </del>		
	nformation is limited to be released and Diagnostic eva	initial items i		Fax transmission.
	Medical records, incl evaluations and diagnostic studies reports Progress notes			
	Results of psy Medical treatm Letter		n only	
				vith other professionals
<del></del>	Other, please	specify:		· · · · · · · · · · · · · · · · · · ·
The purpose for	the record/informa	ition is:		
I fully understand the dates stated above information. The mand confidential and that information discovered by laware to be disclosed I may revoke this a good faith reliance signed my authorized.	he following: My medic e may contain mental he nedical records and/or in ad may be disclosed on sclosed pursuant to this I may inspect and arra I. <b>This authorization e</b> outhorization at any time on this authorization) be	cal record and/or in the alth and develop information authorization may authorization may ange for photocopy appression of the expossion of the authorization authorization on sequences to me although the authorization of the authorization authorization of the a	nformation in connumental disabilities, rized to be disclose ation except as requy be re-disclosed bear from the date extent that action ha itten revocation recon, my medical recons	ection with the treatment alcohol or drug abuse ed hereunder are privileged juired by law. I understand by the recipient and may not healthcare information that
Signature of Client	//	_/	gnature of Parent/0	// Guardian Date