From Outside Source to Dr. Schultz

Center for Health and Healing, S.C.

Fred James Schultz, M.D. • Family Practice
2150 Manchester Road, Wheaton, IL 60187
Phone: 630-933-9722 • Fax: 630-933-9724

Authorization for Release of Medical Information

(Please complete in full.)

1. Patient:

Name: _____ Date of Birth _____
Last First MI

_____
Street Address

_____ Phone _____
City State Zip

2. Authorize records release TO:

Fred James Schultz, M.D
2150 Manchester Road
Wheaton, IL 60187

3. Records released from:

Name: _____

_____
Street Address

_____ Phone _____
City State Zip

4. Type or extent of information to be released: (please check all applicable categories).

- ☐ Medical History, Examination, Reports
- ☐ Treatment or Tests
- ☐ X-ray Reports
- ☐ Laboratory Reports
- ☐ Prescriptions
- ☐ Consultations
- ☐ Surgical Reports
- ☐ Hospital Records Including Reports
- ☐ Mental Health Records
- ☐ Alcohol, Drug Abuse Reports
- ☐ HIV Test Results
- ☐ Copies of All Other Reports/Correspondence

5. Purpose or need for release: _____

6. This authorization will remain in effect for one year from the date the authorization was signed.

7. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

Patient signature _____ Date: _____
(If signed by person other than patient, state relationship to patient)

Patient is: ☐ Minor ☐ Incompetent ☐ Deceased

Legal Authority: ☐ Parent or Legal Guardian ☐ Next of Kin of Deceased