ADVANCED PAIN & SPINE MANAGEMENT

121 S Wilke Rd, Suite 110
Arlington Heights, IL 60005
Phone: (847) 797-4888
Fax: (847) 739-0978

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medial records, or a summary or narrative of my protected health information, to the physician/facility entity listed below.

Patient Name: _____ Date of Birth: _____

Records Requested From:

Name of Physician or Facility _____

Practice Address _____

City, State, and Zip Code _____ Phone _____

Email _____ Fax _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify below)

Other:_____

Please release my protected health information to the following physician/facility/entity and/or those directly associated with my medical care:

Name: Dr. George Macrinici, MD
Address: 121 S Wilke Rd, Suite 110
City: Arlington Heights **State:** IL **Zip Code:** 60005
Phone: (847) 797-4888 **Fax:** (847) 739-0978

The purpose/reason for the release of information is as follows:

☐ Continued Patient Care	☐ Insurance	☐ Social Service/Disability
☐ Worker's Compensation	☐ Personal	☐ Other _____

Patient Signature: _____ Date Signed: _____