



**AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS**  
(PLEASE PRINT OR TYPE)

**1. I HEREBY AUTHORIZE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. TO RELEASE TO:**

BECKER FAMILY MEDICINE, SC  
181 S LINCOLNWAY  
NORTH AURORA, IL 60542  
Phone: (630) 552-9046 Fax: (847) 787-0945

**3. INFORMATION TO BE RELEASED:**  FULL MEDICAL RECORDS  LAB REPORTS  X-RAY REPORTS  
 OTHER (Specify) \_\_\_\_\_

**4. RECORDS FROM THE TIME PERIOD:** \_\_\_\_\_ **TO:** \_\_\_\_\_  
(Specify Dates)

**5. SPECIAL PERMISSION IS REQUIRED TO RELEASE OTHERWISE PRIVILEGED INFORMATION. PLEASE RELEASE RECORDS PERTAINING TO:**

Alcoholism  Drug Abuse  Mental Health  HIV Test Results, AIDS or AIDS Disease  
 Other \_\_\_\_\_

**6. PURPOSE OR NEED FOR DISCLOSURE:** (Check applicable categories)

Insurance Change  Moving to new community  Transferring to new MD  Disability  
Determination  Other \_\_\_\_\_

**7. I UNDERSTAND THAT THIS AUTHORIZATION WILL BE VALID FOR ONE (1) YEAR UNLESS OTHERWISE STATED BELOW OR REVOKED THROUGH WRITTEN NOTICE TO THE MEDICAL RECORDS OFFICE. I ALSO UNDERSTAND THAT THIS INFORMATION HAS THE POTENTIAL TO BE REDISCLOSED AND AT THAT POINT MAY NO LONGER BE PROTECTED HEALTH INFORMATION.**

**8. PATIENT IDENTIFICATION**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Maiden Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City / State / Zip

\_\_\_\_\_  
date:

\_\_\_\_\_  
Home Phone#

\_\_\_\_\_  
Work Phone #

**9. SIGNATURES**

\_\_\_\_\_  
**SIGNATURE** of Patient or Legal Guardian / **DATE**

\_\_\_\_\_  
Relationship of Guardian to Patient/Date/Time

Patient is:

Minor  Incompetent  Disabled  Deceased Birth

Legal Authority:  Legal Guardian  Next of Kin

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives deceased patient, an adult member of the deceased patient's immediate family may qualify. A court-appointed temporary guardian may also qualify. Treatment, payment or eligibility may not be conditioned upon obtaining the patient's authorization.

A PHOTOCOPY OR FAX OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL.