MORRIS FAMILY HEALTHCARE & WELLNESS
MEDICAL RECORDS REQUEST

1802 N Division Street, Suite 201
Morris, IL 60450
Phone: 815-513-5625
Fax: 815-513-5624

Please send records to (check one):
________ Bradley R. Lawton, MD
________ David G. Vermillion, MD
________ Dawn Hawkins, APN

1. AUTHORIZATION FOR REQUEST OF PATIENT HEALTH INFORMATION

Patient Name: ____

Address: ____
Street City Zip Code

Phone: ____________________ Date of Birth: ____________________

I authorize the following Doctor/Healthcare Provider to RELEASE information from my medical record:

Doctor's Name: ____

Address: ____
Street City Zip Code

Phone: ____________________ Fax # ____________________

2. EFFECTIVE PERIOD - This authorization for release of information covers the period of healthcare from:

A. From ____________________ To ____________________

OR

B. __________ I authorize the release of SPECIFIC labs, tests or notes:

From ____________ To ____________ and/or details: ____________________

3. EXTENT OF AUTHORIZATION

A. __________ I authorize the release of my COMPLETE health record INCLUDING records relating to HIV or AIDS, Sexuality, Communicable Diseases, Mental Health and Substance Abuse*

OR

B. __________ I authorize the release of my COMPLETE health record EXCLUDING records related to the Following:

__________ Communicable Diseases (including HIV and AIDS)*

__________ Sexuality* __________ Mental Health**

__________ Alcohol / Drug Abuse** __________ Other** (Please Specify): ______________

**Signature of minor is REQUIRED if over 12 years of age if any of the above 3A or 3B items are checked ____________________________________

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MEDICAL RECORDS REQUEST CONTINUED

C. __________ I authorize the release of results / exam findings to my spouse, power-of-attorney or other

(Specify)____

- **These medical records may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.**
- **This authorization will automatically expire one year from the date signed. I understand that I have the right to revoke this consent, in writing, at any time except to the extent that action has been taken in reliance thereon.**
- **I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.**
- **I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.**

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and his/her relationship to patient

____

Date