South Chicago Orthopedic Specialists, S.C.
1701 W Monterey Avenue
Suite 4
Chicago, IL 60643
Phone: 872-228-0235
Fax: 773-530-0520

SCOS
South Chicago Orthopedic Specialists, S.C.

Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care _____ Military _____ Social Security/Disability _____

Insurance Personal Use Other: _____ Legal Purposes School _____

INFORMATION TO BE RELEASED OR ACCESSED: Please Circle.

History & Physical	Operative Reports	Lab/Path Reports
Consultation Report	Discharge/Death Summary	X-Ray Reports/Images
Emergency Room Record	Face Sheet	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

FROM: _____

_____

_____

_____

TO: South Chicago Orthopedic Specialists, SC.
1701 W Monterey Avenue, Suite 4
Chicago, IL 60643
Phone: 872-228-0235 / Fax: 773-530-0520

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient