Northwest Eye Clinic, Ltd.

1400 Golf Road, Suite 212
Des Plaines, IL. 60016-1252
Phone (847) 296-4020
Fax (847) 984-1894

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Dear Doctor _____

I hereby request and authorize you to copy and release last 3 years of medical records or as detailed below:

o Full medical records held by this office

o Medical records for the dates of _____to_____

o Only a specific portion of the record as follows _____

_____

_____

_____

○ I request that the records be released to Northwest Eye Clinic, Ltd., listed above

○ I request that the records be released to the patient, located...

○ I request that the records be released to doctor, located...

Address _____

_____

By signing this document I release you from all legal responsibility or liability that might arise from the furnishing of medical records as authorized by this letter.

Patient Signature	Authorized Legal Representative	Date