AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____DOB:_____
Previously Known As:_____

I hereby request and authorize:

Name of Practice:_____
Address: _____

To release the information specified below to:

Name: Dr. Thao Nguyen Tran
Address: 1641 N Milwaukee Ave, Ste 10 Libertyville, IL 60048
or Secondary address: 7201 Green Bay, Suite C, Kenosha, WI 53142
(847)457-3688 (O), (262)842-2358 (O) (888)959-8367 (FAX)

Please send the following Items:

□ Progress Notes/ Treatment Forms Dates:_____
□ Diagnostic Reports _____
□ Inpatient Records _____
□ Other (specify):_____

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure. There may be a charge for copies of medical records to be released if the purpose is not for continuing care. I also understand that this authorization may be revoked by me at any time by written notification to the organization identified in the first section above. Revocation, however, cannot be retroactive. This consent is valid for 60 days from the date of signature unless otherwise specified here_____.
A photocopy of this document should be considered as valid as the original.

_____ _____ _____ _____

Signature of Patient Date OR Signature of Parent/Legal guardian. Date

Relationship _____