

RECORDS RELEASE AUTHORITY

TO: _____

I, _____ hereby request that
(Patient's name or guardian)
you release to:

CENTER FOR INTEGRAL HEALTH

400 E. 22nd St., Suite F
Lombard, IL 60148
Telephone: (630) 792-9311

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data
pertinent to your treatment of me from _____ to _____.

(Date of Request)

(Patient's Signature)

(Witness)

(Address)

(Date)

(City, State, Zip Code)