The Eisenstein Clinic

Release of medical records

Authorization to Transfer Medical Records Authorization I hereby authorize _____ to release any and all medical records, including but not limited to hospitalization for diagnosis and/or treatment of psychiatric and/or mental condition, alcoholism, drug abuse and/or HIV test results, AIDS, or AIDS related conditions.

Release to: Name: Jennifer Eisenstein APRN, DNP

Practice: The Eisenstein Clinic

Address: 415 West Golf Road Suite 2

City: Arlington Heights

State: Il

ZIP: 60005

Office: 847-329-2020

Fax: 847-258-4548

Uses the purpose of the release of this information is: Continuity of Medical Care _____ Restrictions the recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law. Duration This authorization will expire 60 days from today or at an earlier date, at my election (To cancel this authorization prior to the above limit, notification must be sent to the Medical Record Department in writing and bear the patient's or legal representative's signature). Patient Information (Please print) Patient's Name:_____ Date of Birth:_____ Date(s) of Treatment: _____

Signatures:

Patient's Signature:_____Date:_____
Witness Signature:_____Date:_____