Suburban Surgical Associates, Ltd.
Suburban Metabolic Institute, LLC
3340 S. Oak Park Ave., Ste. #309
Berwyn, IL 60402
Phone# 708-484-0621 Fax#708-484-0250

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information-Please complete all blanks **Today's Date: _____**

Name: _____ **Date of Birth: _____**

Address: _____ **Phone #:_____**

City/State/ZIP: _____

I authorize Suburban Surgical Associates, Ltd. / Suburban Metabolic Institute, LLC to release patient records to:

Name of Individual Organization_____

Address:_____City:_____State:_____Zip:_____

Method of delivery: Check preferred method of delivery

- **Via Fax**
- **By US mail**
- **Call for pick up by the patient or their legal representative. All records will be held at the site for pick up after payment is received. *A PHOTO ID IS REQURED TO PICK UP RECORDS*.**

Name of person picking up the records, if other than the patient: _____

The purpose of the disclosure is:

__Continuation of Care __Personal reasons __Insurance __Other (fill in) _____

INFORMATION REQUESTED

- Please note that "all records" or incomplete treatment dates will NOT be considered specific.

__Identify Specific Dept./Physician/Location:_____

__X-Ray __Ultrasound __C.T Scan __Cardiac testing __Labs __Medication List __Progress Notes

__ Other_____

For Treatment dates of treatment; _____

(For example: specific date 01/25/11; range of dates Jan-July 2011)

***Page 1 and page 2 of the authorization must be completed.**

Signatures

- I understand that I have the right to revoke this authorization at any time. I understand the revocation must be in writing and must be sent to the attention Suburban Surgical Associates, Ltd./Suburban Metabolic Associates, LLC at 3245 S. Grove Ave., Ste#202, Berwyn, IL 60402.

- I understand that this authorization will terminate in 90 days or upon the following specified date or event , whichever is shorter:

  _____or_____
  (Specified Date) *(Specified event)*

- I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by law.

- I understand I have the right to inspect and/or receive a copy of the medical information to be used or disclosed and also receive a copy of this authorization by law.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPSE STATED ABOVE.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Representative Date
(Generally required if patient is under 18 yrs. old or incompetent)